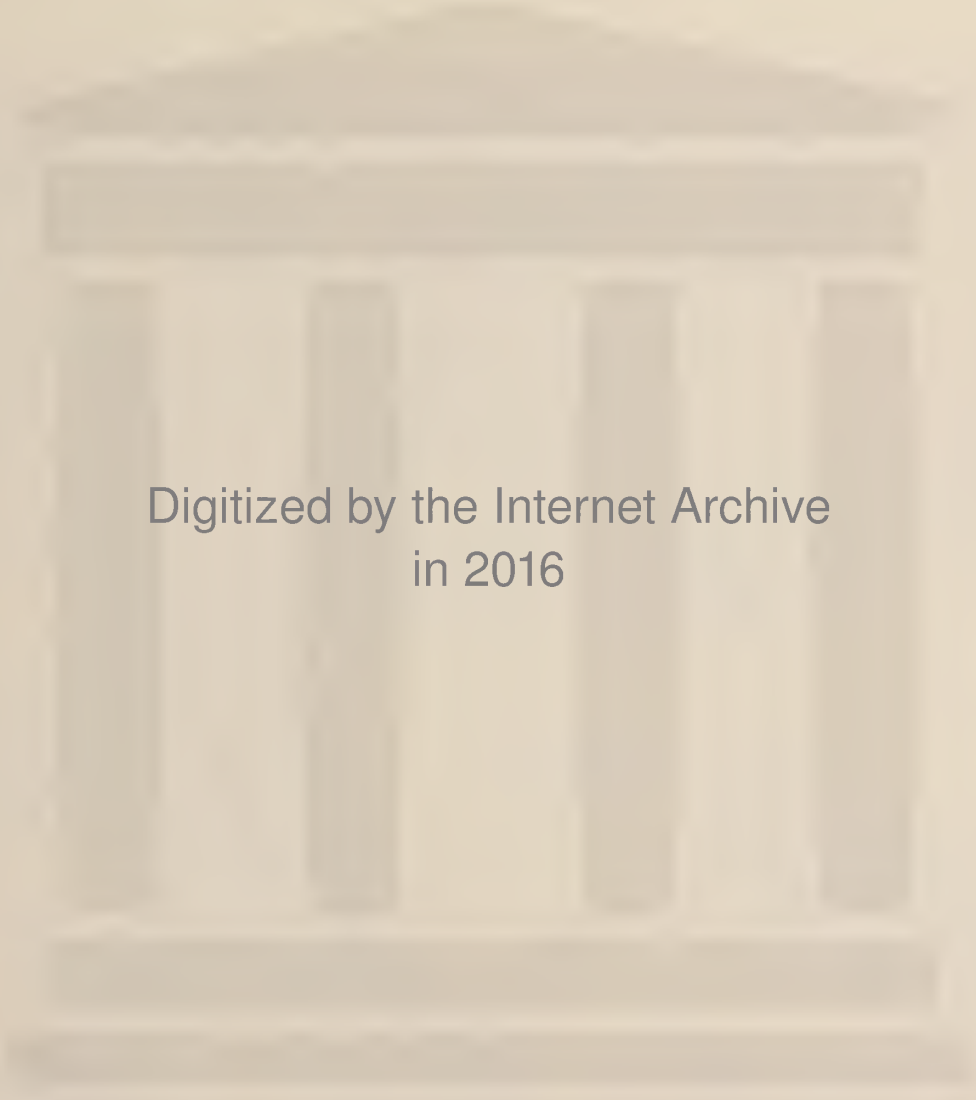
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Chagas' Disease: A Case In South Mississippi

ROBERT D. HOLBERT, MD
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C. P. HIRSCH, MD
S. J. NUNENMACHER, MD

Chagas' Disease is common in Central and South America. As the number of immigrants increase in the United States and North America the incidence of Chagas' Disease is increasing. This is a report of chronic Chagas' Disease diagnosed on the Gulf Coast. A review of the recent literature suggests seropositivity in the United States to be approximately 350,000 people with approximately 100,000 cases of chronic Chagas' Disease. The triad of cardiomegaly, megaesophagus, and mental disease are common symptoms. A case report, literature review, epidemiology, and diagnostic studies are presented.

Chagas' Disease is common in South America whereas it is rare in the United States and the rest of North America. Chagas' Disease is endemic in tropical Latin American countries and is becoming epidemiologically important in the United States. We recently diagnosed a patient with cardiomegaly secondary to Trypanosoma cruzi while the patient was living in south Mississippi.

In 1909 Carlos Chagas discovered a flagellate in the hind gut of a Triatomid bug which he later described in the common house cat and in a child. He named the organism Schizotrypanum cruzi. The Triatomid bug is the important vector for the mammalian host. While the infected bug is taking a blood meal it discharges excrement containing the metacyclic Ttypomastigotes onto the skin. The excrement is rubbed into the wound where the parasites are

engulfed by macrophages. Multiplication is accomplished by intracellular binary fission with the resultant production of leishmania forms. This multiplication is followed by rupture of the macrophages and subsequent invasion and replication in other macrophages in the surrounding tissue. After 4 or 5 days the leishmania is transformed to the Trypanosome stage and is discharged into the blood stream. The blood borne parasite is carried to the visceral tissue where it is transformed into the intracellular leishmania form once again. The organism may then be transmitted by blood feedings or through the mucous membranes from ingested infected tissue. Congenital or transmammary transmission has also been reported.[1,2]

The epidemiology of Chagas Disease is important in that most of the cases occur in Latin America. Immigration patterns of South Americans into the United States over the past 30 years suggest that there would be 350,000 or more individuals with seropositivity for T-cruzi living in the United States today.[3,4] It is expected that 100,000 individuals will have chronic cardiomyopathy due to T-cruzi. Mammalian blood hosts for T-cruzi are known to be infected in the United States. Blood smears and serologic studies have revealed the presence of T-cruzi in the raccoon, opossum, armadillo, and canines in Louisiana and Florida.[8-11] Seropositivity for T-cruzi has been recognized as far north as Maryland in the United States.[1]

Our patient B.G., is a 61 year old female who came to the clinic on October 16, 1992 complaining of vomiting cephalgia and chest pain. The patient was admitted to the hospital for acute medical management. She was noted to have a normal chest x-ray and a normal EKG. The patient's discharge diagnoses were atypical chest pain, gastroenteritis and anxiety. The patient was next seen in the clinic on October 26, 1992 and was felt to be doing well. She was seen on September 1, 1993 complaining of shortness of breath and difficulty voiding urine. Her examination on that visit revealed rales in her chest consistent with congestive heart failure. A chest x-ray revealed cardiomegaly with radiologic evidence of congestive failure. The patient was admitted to the hospital with a diagnosis of dilated cardiomyopathy. The etiology of her cardiomyopathy was undetermined at that time.

PAST HISTORY

The patient has been evaluated for atypical chest pain several times over the past 3 years. She had a cardiac catheterization performed in April of 1992 which was felt to be within normal limits. In February of 1992 she had an esophagogastroduodenoscopy which revealed mild reflux esophagitis. She was treated with H_2 blockers and later changed to Ptilosec without significant improvement. Due to continued symptoms an esophageal motility study was performed revealing very low lower esophageal sphincter pressure with absent peristalsis in the esophageal body. Scleraderma was a consideration but was ruled out by appropriate tests. The patient was never diagnosed as having megaesophagus during her GI evaluation. The patient has undergone long term psychiatric treatment and was hospitalized in July of 1993 with acute depression. She was evaluated at that time for shortness of breath. She was treated with oral diuretics with resolution of her symptoms. She had also been diagnosed as having a large cystocele and rectocele with recurrent urinary tract infections.

SOCIAL HISTORY

The patient is a non-smoker non-drinker Hispanic female who is divorced and living with her daughter in Gautier Mississippi. She is an immigrant to the United States from Brazil approximately 20 years ago. She remembers up until age 10 living in a dirt floor shanty.

FAMILY HISTORY

The patient has a strong family history of heart disease and early death in multiple family members. She remembers many of her siblings having been ill and dying at a very early age. She remembers one brother in particular who swelled and died subsequent to this swelling. She is not aware of Chagas' Disease nor does she have a knowledge of Chagas' Disease in her family.

REVIEW OF SYSTEMS

In general the patient has good health. She primarily had difficulty associated with psychiatric problems recurrent GI tract pain atypical chest pain, cystocele rectocele, and shortness of breath. The remainder of her review has been negative.

PHYSICAL EXAM

The patient's blood pressure was 150/90. Her body weight was 180 pounds. Her pulse was 98. Her respiratory rate was 20. In general the patient was an obese female in no distress. She was oriented to time, place and circumstance. Examination of her head, ears, eyes, nose, and throat revealed that her tympanic mem-

branes were mildly erythematous. She was also noted to have erythema of the nasal mucosa. Her neck was supple with an increased external jugular pressure. Her heart exam revealed a soft S3 gallop. Examination of her lungs revealed her to have rales in both lung fields. Retractions were not noted. Her heart rate was noted to be irregular consistent with an occasional extra systolic beat. The patient's abdomen was diffusely enlarged with direct mid colon epigastric tenderness. Bowel sounds were normal. Pelvic exam revealed a large cystocele and a large rectocele. The patient's extremities revealed her to have mild pitting edema of her lower extremities. Her chest x-ray revealed marked cardiomegaly with congestive failure. Comparison of her films of October 16, 1992 revealed an approximate 30% increase in size of the cardiac silhouette. It was felt that she had biventricular enlargement based on the cardiac silhouette. Her admission diagnosis was cardio-megaly with congestive failure.

HOSPITAL COURSE

The patient was placed in the cardiac step down unit with telemetry monitoring. Consultation was asked from the cardiologist an the gastroenterologist. The patient was treated with small doses of intravenous Lasix and oral ACE inhibitors. The patient progressed without complication until day 4 of her hospitalization when she had an acute cardiorespiratory failure secondary to a ventricular tachyarrhythmia. She required short term ventilation in the Intensive Care Unit. Once the patient had been stabilized she was transferred to Gulfport Memorial Hospital where she received a permanently placed defibrillator. Because of the patient's history of psychiatric disorder, esophageal disorder, cardiomegaly and being from an endemic area she was evaluated for Trypanosoma cruzi serology. The patient's titres were positive for IGG at 1 to 256. Chagas' Disease levels are usually greater than 1 to 64. The patient was seen in clinic on October 30, 1993 and was doing well without cardiac complaint.

DISCUSSION

Chagas' Disease in the United States is becoming more recognized. It has been seen as a clinical problem as far north as Maryland in the United States.[2,3] The parasite has at least five methods of transmission in North America: vector borne, congenital, blood transfusion, tissue transplantation and in laboratory technicians. As of this review there have been three cases of acute Chagas Disease in North America thought to be related to vector transmission.[1,4,5] There is no biological reason that the parasite cannot exist in the local environment. T-cruzi is found in the wild in multiple animal species [7-9] and the insect vector is present in North America.[10,11] The assumption that our form of housing prevents exposure of the population to the Triatomid bug is used to describe our low incidence of Chagas' Disease.[1] The parasite is present in the wild animal population and has been seen in Louisiana in the domestic dog population. It may be underdiagnosed as well as low in incidence. The acute disease is very much like a viral respiratory illness and unless there is a high level of suspicion it would not be considered in the differential diagnosis. The disease process does not have characteristics which would make the clinician suspicious of acute Chagas' Disease especially in illnesses of the pediatric age group.[3]

Chronic Chagas' Disease is much more likely to present in the United States. Studies have shown an increased incidence of seropositivity in the populations that are known to have an increased number of immigrants from Latin America. 1.1 percent of blood donors in a Los Angeles medical center were found to be seropositive for T-cruzi.[5,6] Based on the incidence of seropositivity and the number of immigrants in The United States today from Central and South America it is suggested that between 35,000 and 100,000 people in the United States would be expected to have Chagas' Disease.[1,2,5] Patients with Chagas' Diseases have multiple episodes of release of T-cruzi into the blood stream. These episodes usually will be associated with a febrile illness. Blood products taken during these episodes of leishmaniasis will be capable of transmission of the acute Chagas' Disease.[2] Chronic disease will be caused by recurrent chagoma formation with the three major organs or organ systems involved being the brain, the heart, and the GI tract. Our patient was admitted to the hospital with clinical symptoms of chest pain, congestive heart failure secondary to a dilated cardiomyopathy, cardiac rhythm disturbance, lower esophageal pain and psychiatric disease. Each of the symptoms involved represent a usual manifestation of Chagas' Disease.

Atypical chest pain with dilated cardiomyopathy is the most common presenting symptom.[3] The atypical chest pain may represent esophageal pain gastroesophageal reflux or cardiac pain. In the esophagus as well as in the cardiac tissue the disease appears to cause dysfunction of the nerve supply in the conductive tissue. The result of this at-

tack on the specialized nerve tissue causes dilation of the esophagus and conduction abnormalities of the heart. Mental disease is possibly associated with chagoma formation in the central nervous system and as a result of glia cell destruction. The dilated cardiomyopathy is a late manifestation of the disease and the cardiac rhythm disturbance associated with the dilated cardiomyopathy is the usual mechanism of death in this patient population. The conductive tissue in the heart apparently is disrupted by chagoma formation and continuous myosite damage as well as loss of normal electrical pathways. The typical arrhythmia is ventricular fibrillation. Our patient did have problems with ventricular fibrillation and required a permanently placed defibrillator. The echocardiogram is not specific in Chagas' Disease but the thinning of the myocardial base is the manifestation seen on the echocardiogram. The basilar aneurysmal dilatation may be the site of slow transmitting myosites that cause ventricular tachycardia. Surgical removal of the aneurysm has reduced the arrhythmia in some patients.[3] Medication for treatment of Trypanosoma cruzi infection has not been effective.

It appears that because of an increased influx of people from Central and South America seropositivity for T-cruzi has become more prominent. North America does not have a high incidence of Chagas' Disease even though the insect vector and parasite are common in the animal population. Blood transfusion has been shown to transmit T-cruzi to patients in North America. Chagas' Disease presents as a dilation of a hollow viscus such as megaesophagus, dilated cardiomyopathy and central nervous system disease. A high level of suspicion will probably result in more diagnoses of Chagas' Disease in the future especially as immigration patterns continue to favor Central and South American influx into the United States. Methods of transmission include the insect vector, intra uterine transmission, exposure of laboratory workers to blood and body fluids by transfusions and by reactivation of the infection in immunocompromised patients such as transplant recipients and HIV patients.

TREATMENT

The Cornerstone of treatment of treatment of Chagas' Disease is prevention. At this time the primary form of prevention is the use of insecticides to control the vector. In the areas where this disease is endemic, further attempts at prevention are limited by the socioeconomic status of those countries. Attention is also paid to the donated blood supply; in endemic areas blood donors are tested for seropositivity to T-cruzi.[12]

Treatment of this disease is frustrating. Nifurtimox is currently the only drug available in the United States. Its effectiveness is limited to the acute stage of the disease. However, it has a multitude of side effects, and the parasites are not uniformally sensitive to it. For a patient such as ours with chronic Chagas' Disease, the treatment if symptomatic and supportative.[12] ❑

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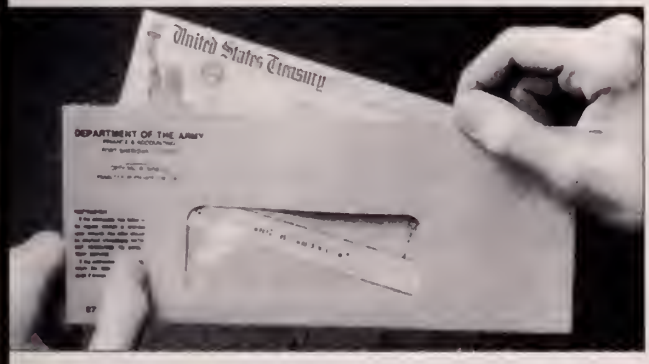
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CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE VIII

Selection and Preparation:
Charles A. Brown, MD
Kurt D. Olinde, MD

Joe C. Files, MD, *Editor*

Differential Diagnosis: **Robin Isaacs, MD**
Pathological Findings: **Cynthia Lynch, MD**

CASE PRESENTATION

A 62 year old white male with a history of bronchiectasis and a 1/2 cup of sputum production per day was seen several times as an outpatient complaining of lower extremity pain and swelling. Ultrasound examination of his legs for deep venous thrombosis was unremarkable and the patient refused venography. A gated heart scan was normal. He was anemic with Hct 32%, MCV 79 u^3, RDW 14. Iron studies revealed iron 7 µgm/dl, TIBC 190 µgm/dl, and ferritin 229 ng/ml.

He was seen on the day of his admission where he continued to complain of lower extremity swelling and pain. At the time he did not complain of any gastrointestinal symptoms but reported a 10 pound weight loss over the preceding six to twelve weeks, and intermittent fevers and drenching night sweats for about two months. He had a dental procedure one month prior to admission. He had had a cholecystectomy and a left inguinal hernia repair in the distant past. He was allergic to sulfonamides and ibuprofen. He was taking chronic suppressive antimicrobials therapy consisting of alternating Amoxicillin, Cephalexin, and Doxycycline, and was also using nebulized albuterol. There was no history of alcohol, tobacco, or illicit drug use and no recent travel. He had no known recent animal or occupational exposures but he had worked for the USDA as a chicken inspector, retiring in 1987. Review of systems was unrevealing.

Physical examination was unremarkable. His temperature was 98.3°F, pulse 100 per minute, respiratory rate 18 per minute, and blood pressure 112/68 mmHg. He had no rashes. Head and neck examination was unremarkable without evidence of meningeal irritation, jugular venous distension, nor carotid bruits. Chest auscultation revealed no added sounds and cardiac examination was unremarkable. The abdomen was soft and non-tender with normoactive bowel sounds and no hepatosplenomegaly; there was a reducible left inguinal hernia. Rectal exam was normal. There was no peripheral edema. Distal pulses were present, of good volume, and symmetrical. There was no muscle tenderness, and examination of his extremities was normal.

Laboratory data included total white cell count of 13.2 x $10^3/mm^3$ (71% neutrophils, 14% lymphocytes, 10% monocytes, and 1% eosinophils), Hct 28.2%, and platelet count 806,000/mm^3. Erythrocyte sedimentation rate was 116 mm in one hour. Biochemical liver function tests were normal except for a serum albumin 2.6mg/dl. Chest radiograph was consistent with bronchiectasis and unchanged from previous examinations.

He was admitted for evaluation. During his hospital course he persistently spiked fevers to 101°F and 101.5°F. A long and unrewarding series of investigations were performed. These included serial chest radiographs, blood chemistries, PPD, hepatitis serologies, hemoccult testing, and cultures of blood, sputum, urine, and bone marrow for bacterial, mycobacterial, and fungal pathogens; all these studies were negative. Rheumatoid factor was 180 IU. Serum protein electrophoresis did not identify a monoclonal peak. Computerized tomography scan of the chest and abdomen was consistent with bronchiectasis. Abdominal ultrasound showed hepatic and splenic "granulomas". Echocardiography was unremarkable. Radionuclide ventilation-perfusion scintigraphic scan revealed no perfusion defects. EMG studies were noncontributory. Multiple urine samples were examined; all demonstrated microscopic hematuria and one of these revealed class III cytology. The patient refused cystoscopy but an intravenous pyelogram was unremarkable. Serology for brucellosis, psittacosis, and Q fever were nonreactive, and cultures for *Brucella* were sterile.

A left axillary lymph node became palpable

during the hospital course but the node biopsy was unremarkable. The reason for his fever was still obscure after four weeks of in-hospital investigations. Empiric treatment for bacterial endocarditis with intravenous Penicillin G and Gentamicin was given for 10 days with no clinical change. A 14 day trial of triple antituberculous medication was then given without resolution of the fever.

He then developed a right foot drop. C_3, C_4, and CH_{50} were normal, cryoglobulins were not detected, and celiac and renal arteriograms were normal. Repeat urinalysis demonstrated red and white blood cell casts. A diagnostic procedure was performed. What was it, what is the diagnosis, and how is it treated?

Dr. Isaacs: This man who had persistent fever with multiple nondiagnostic studies finally developed clinical findings which indicated the diagnosis. I will discuss this case initially without considering these diagnostic clinical findings because clearly the physicians involved with this patient did not find anything obvious in his presenting condition.

The patient is an elderly Caucasian male with long standing bronchiectasis, lower extremity swelling and pain, recent weight loss, documented fever for at least two months prior to admission, and dental work one month prior to onset of his fever. The chronic antimicrobial use complicates his assessment from two points of view: 1) could this be drug fever, and 2) the antimicrobials may suppress a microbiologic diagnosis. He was not taking either of the drugs to which he was known to be allergic. The social history is important for several reasons. He was a non-smoker, a non-drinker, and had never used illicit drugs. His employment with the USDA up to 1987 suggests potential exposure to agricultural pathogens. On examination at the time of admission there was no clinical evidence of endocarditis, no adenopathy, and no central nervous system abnormality.

The hospital course was characterized by persistent fever and laboratory evidence of chronic inflammation; i.e. anemia, leukocytosis, thrombocytosis, hypoalbuminemia, elevated erythrocyte sedimentation rate, and a rheumatoid factor of 180 IU. These laboratory findings are nondiagnostic and are consistent with a diagnosis of long standing bronchiectasis. The other features of his hospital course were persistent microscopic hematuria, multiple unrewarding examinations, and failed therapeutic trials for bacterial endocarditis and tuberculosis. All microbiologic studies including studies for routine bacterial pathogens, fungi, and mycobacteria were unrewarding. Axillary lymph node biopsy was unhelpful and EMG did not demonstrate findings consistent with Lambert-Eaton syndrome.

This patient has fever of unknown origin (FUO). Prior to discussing this patient's diagnosis I will discuss FUO so that we can develop a broad framework for investigation of such patients. FUO remains one of the major diagnostic challenges open to internists.[1] This patient is typical of a small but significant group of patients in which extensive investigation fails to identify the cause of the fever.[2-8] In 1961, Petersdorf and Beeson proposed this definition of FUO[3]: an illness of more than three weeks duration characterized by fevers greater than 101°F and the diagnosis is still uncertain after one week of in-hospital study. The patient under discussion fits this diagnostic group.

How do we investigate a patient with FUO? There is no right or wrong way in which to approach the patient with FUO but there are some important considerations. A good history and physical examination is essential and it needs to be performed at the time the patient presents. An often forgotten component of the history is a detailed analysis of animal and occupational exposures. For example, such details may be critical in the diagnosis of cat scratch fever or psittacosis. Similarly, nocturnal fever may be the manifestation of hypersensitivity reactions to occupational allergens. A detailed travel history is important and needs to include not only overseas travel but travel within the United States itself. For example, coccidioido-mycosis is a consideration if a resident of Mississippi travels to California. Finally, it is important to establish the sexual orientation of the patient and whether the patient uses illicit drugs.

One should then perform a logical and organized investigation based on the clues that have been obtained from the history and the examination and based on general knowledge of the conditions associated with FUO. It is impossible to investigate every possible cause of FUO in every patient; it is the history and examination which will act as the guide.

In general, try to obtain material for culture from as many sites as possible including blood, sputum, urine, and if necessary, bone marrow. Furthermore, material should be examined by direct microscopy as will as being plated for culture. Blood cultures will be an important investigation. As there are a number of slow-growing fastidious organisms which can cause FUO, it is important to

ask the microbiology laboratory to monitor blood cultures for 21 days. Prolonged culture is particularly important when the patient has been using antimicrobials prior to admission; in addition the yield of blood cultures in such patients can be enhanced by increasing the volume of blood added to each culture bottle and/or by the addition of -lactam binding resins to the blood cultures. Similarly, the laboratory has to be told that you a interested in fungal and mycobacterial cultures as well as routine bacteriology.

In general, non-invasive investigations should be used in preference to invasive studies unless there are clear indications for the invasive studies. Although 'blind' liver biopsy and exploratory laparotomy have been in vogue at various times in the past, modern imaging techniques such as computerized axial tomography and magnetic resonance imaging can often times provide similar information.[9] Similarly, computerized tomographic- or ultrasound-guided fine-needle biopsy/aspiration may avoid the need for a major surgical procedure. Finally, if a biopsy is performed then make sure that every possible piece of information is obtained from it; hence, submit the material for routine bacteriology, fungal, viral, and mycobacterial culture, as well as for histopathology.

It is difficult to provide dogmatic guidelines since every patient with FUO is different but if one follows these general principles, the diagnosis will become apparent in about 90% of the patients.[1-8] If the diagnosis remains obscure and the patient remains clinically stable, then avoid the temptation to start treatment since time will often provide a diagnosis as the underlying disease progresses.[9] Interestingly, two therapeutic trials were undertaken in this patient before the diagnosis became clear. The physicians involved in the management of this patient were sufficiently concerned about the possibility of either subacute bacterial endocarditis or mycobacterial infection to initiate treatment trials in a logical progression. The presence of fever 10 days into treatment of a patient with endocarditis is suggestive of uncontrolled infection[10]; conversely, the majority of endocarditis patients will become afebrile within seven to 10 days of appropriate treatment. Similarly, the majority of febrile tuberculosis patients will respond to treatment within 14 days.[11,12] This patient failed both therapeutic trials and it was observation over time which established the diagnosis in this case.

What are the causes of FUO? Prior to discussing the more common causes it is important to be aware of the syndrome of factitious fever. I have never been involved with such a patient but the diagnosis needs to be entertained in those patients with FUO where a diagnosis is not reached. It is also important to consider the possibility of drug fever.[13]

FUO can be subdivided basically into those caused by infection, those caused by neoplastic conditions, those caused by connective tissue disorders, and then a group of miscellaneous causes[1-6] (Table 1). Neoplasia seems to be playing an increasingly important role in modern series. Fever is classically associated with lymphoma but any malignancy can cause fever; other solid tumors commonly presenting with fever include hepatoma and renal cell carcinoma.

Table 1. Change in FUO from 1952-1980

	Yale 1952-1957 (3)	Seattle 1970-1980 (4)
Infections	36%	30%
Neoplasia	19%	31%
Connective tissue disorders	13%	8%
Miscellaneous	25%	17%
No diagnosis	7%	12%

Infections which need to be specifically considered include viral, fungal and mycobacterial infections, renal tract infections, endocarditis, and intra-abdominal abscess; e.g., pyelonephritis in the presence of complete ipsilateral ureteric obstruction can be difficult to diagnose because the urine culture may be sterile. Diagnosis of even a simple infection may be difficult if the patient has been partially treated with antimicrobials.

Although any connective tissue disorders can present with fever, there are two conditions which merit special mention: giant cell arteritis and adult onset, juvenile rheumatoid arthritis. These two conditions can be very difficult to diagnose and one needs to actively consider the diagnosis in any patient with FUO.

There are a number of miscellaneous conditions associated with FUO. Pulmonary embolism is the commonest of these conditions and was excluded in this patient by the normal perfusion scan. Other conditions include hematomas (particularly retroperitoneal), inflammatory bowel disease, sarcoid, alcoholic hepatitis, and granulomatous hepatitis.

Table 2. FUO in patients over 65 years of age (8)

Infection	37%
Neoplasia	23%
Connective tissue disorders	26%
Giant-cell arteritis (17%)	
Polyarteritis nodosa (6%)	
Others (3%)	
Miscellaneous	9%
Pulmonary embolism (5%)	
Others (5%)	
No diagnosis	5%

This patient was 69 years old. Is there any difference in the way elderly patients present with FUO as compared with younger patients? At least according to one published series[8] (Table 2), connective tissue disorders appear to be more common in the elderly. In this series of 111 patients, there were 28 cases of connective tissue disease associated with FUO; approximately 75% were caused by temporal arteritis and the remainder were predominantly caused by polyarteritis nodosa.

This overview of FUO gives a perspective as to the potential diagnoses in this patient. On reviewing the diagnostic studies in this patient, it is clear that the physicians followed a logical approach based on the framework of usual FUO causes. The ultimate diagnosis, however, was not revealed until the patient developed a mononeuritis multiplex and an active urinary sediment.

Table 3. Mononeuritis multiplex (after (14))

Diabetes mellitus	Angiopathic neuropathies
Ischemic neuropathy	Polyarteritis nodosa
Sarcoid	Rheumatoid arthritis
Sicca syndrome	Systemic lupus erythematosus
Idiopathic	Scleroderma
	Giant-cell arteritis
	Wegener's granulomatosis
	Non-systemic vasculitic neuropathy

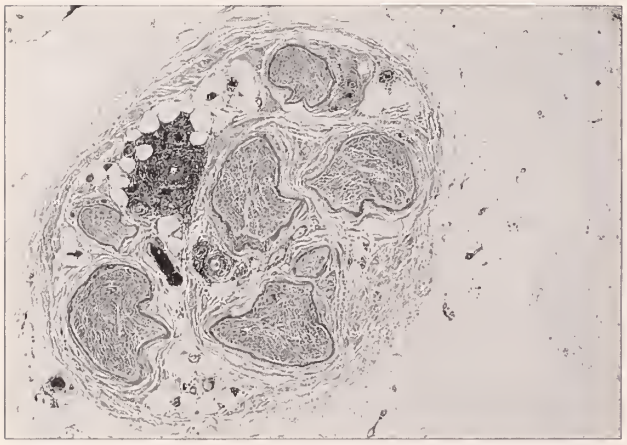
Mononeuritis multiplex is associated with a number of conditions including diabetes mellitus and connective tissue disorders (Table 3). About one third of patients with mononeuritis multiplex have no apparent associated disease. There a several types of neuropathy associated with diabetes mellitus including a painful asymmetric mononeuritis multiplex which tends to occur in older patients who have mild or nondiagnosed diabetes. Ischemic neuropathy in patients with peripheral vascular disease can present as mononeuritis multiplex. After diabetes mellitus, the next most common cause of mononeuritis multiplex is angiopathic neuropathies or vasculitides, and of these polyarteritis nodosa is the most common cause. Thirty to 70% of patients with polyarteritis nodosa will have histological neurological involvement, and approximately half of these patients will have clinical evidence of neurologic involvement. Patients with systemic lupus erythematosus and rheumatoid arthritis can present with a mononeuritis multiplex but they generally have established or severe disease.

I believe that this patient has polyarteritis nodosa and the diagnosis was established by biopsy of the affected nerve. Polyarteritis nodosa is a focal necrotizing arteritis with a predilection for small and medium sized arteries and in particular, the bifurcation points of the arteries.[15] It is a rare syndrome with a male:female ratio of 2:1. The etiology is unknown but the disease has been associated with viral infections, in particular chronic hepatitis B antigenemia. As with other vasculitides, patients can present in many different ways depending on which organ system is first affected. Constitutional symptoms such as fever and parameters of chronic inflammation may precede, antecede, or develop after visceral involvement. Cutaneous lesions are characteristically vasculitic and range from classic palpable purpura, through livedo reticulosis to cutaneous infarction syndromes. As discussed above, neuropathy is very common and mononeuritis multiplex is a common presenting feature; in contrast, central nervous system involvement is rare. About 70% of patients will have renal involvement with an active urinary sediment and proteinuria. About half the patients develop either arthralgia or an asymmetric, non-deforming large joint arthritis. Abdominal pain is also a common feature. The pulmonary system is rarely involved. Laboratory tests are generally nondiagnostic and are consistent with a chronic inflammatory process. Eosinophilia is present in some patients. The role of visceral angiography is controversial; saccular aneurysms may be demonstrated at bifurcation of intra-abdominal arteries, particularly branches of the mesenteric vessels, but this finding is not specific being present in other diseases including Wegener's granulomatosis, Churg-Strauss syndrome, systemic lupus

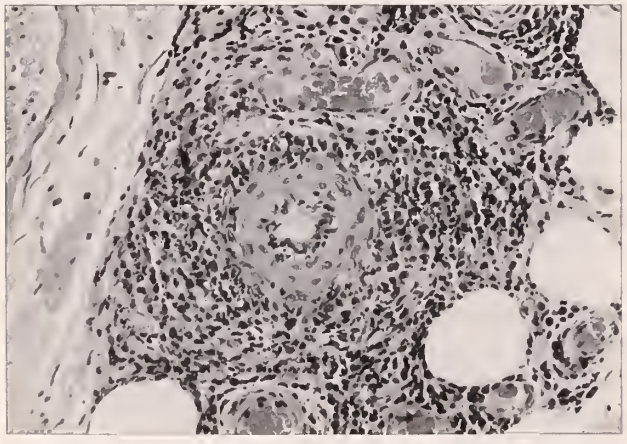
erythematosus, thrombotic thrombocytopenic purpura, endocarditis, and peritoneal metastatic malignancy. Visceral angiography probably should be reserved for those patients where there is no tissue available for biopsy. Treatment with glucocorticoids plus/minus cytotoxic agents has improved 5 year survival from 15% to 50%.

In summary, I believe this man has polyarteritis nodosa manifesting initially as an FUO and subsequently as mononeuritis multiplex with an active urinary sediment. The diagnostic procedure is a sural nerve biopsy and treatment will be with glucocorticoids plus/minus cytotoxic agents. This case demonstrates the difficulties in diagnosing FUO and highlights the point that observation of the patient over time is often the key diagnostic maneuver.

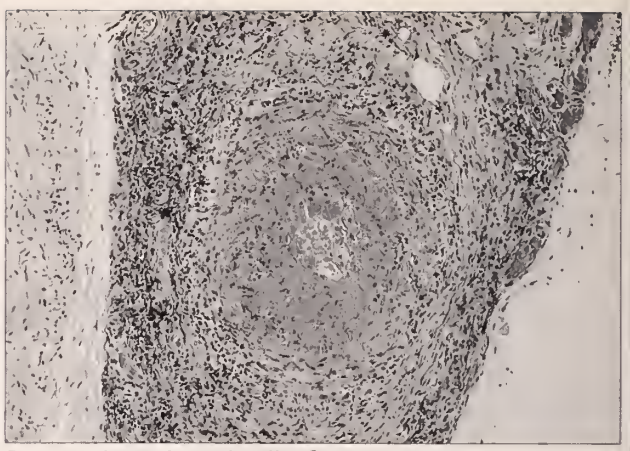
Dr. Lynch: The photographs below show the cross section of the sural nerve biopsy that we received. The nerve is unremarkable. There is a pronounced inflammatory reaction around a medium-sized artery. All the vessels seem to be involved to some degree. This arterial wall is completely obscured by smudgy eosinophilic material which is what we refer to as fibrinoid necrosis. Surrounding is an inflammatory infiltrate composed of neutrophils, a few scattered eosinophils, lymphocytes, and plasma cells. Most importantly we see that the neutrophils are moving through the wall of this vessel. In this patient there were various stages of vasculitis. Some vessels showed fibrinoid necrosis with the neutrophils. Others were more in a chronic or perhaps a healing stage where the infiltrate was more lymphocytic with intact vessel walls. Polyarteritis nodosa often is sporadic. One segment of the vessel may be completely normal while another could have fibrinoid necrosis. Involvement is often at a branch point. Veins can be involved by proximity and usually their involvement is minimal with a few lymphocytes trickling into their wall. There can be ischemic damage to the various organs because involved arteries can thrombose or eventually completely close off with the healing process. The muscle biopsy showed many of the small and medium sized



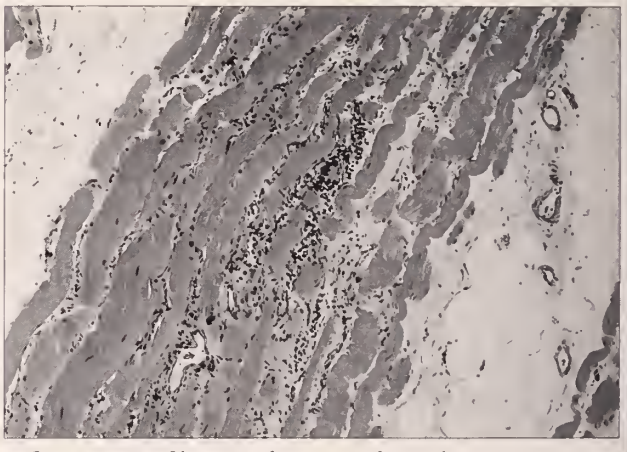
Cross section of sural nerve showing perivascular inflammation



Perivascular inflammation composed of neutrophils, lymphocytes, and plasma cells.



Perivascular and vessel wall inflammation with fibrinoid necrosis.



Inflammatory infiltrate within striated muscle.

arteries with inflammation and inflammation scattered throughout the muscle. This would lead to muscle loss and weakness.

Diagnosis: Polyarteritis nodosa ❑

2500 North State Street
Jackson, MS 39216

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***Dr. Brown** and **Dr. Olinde** were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center, 1992-1993.*

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Mississippi State Board of Medical Licensure Annual Report

July 1, 1993 Through June 30,1994

The Mississippi State Board of Medical Licensure is the State's legally constituted licensure Board for physicians (M.D./D.O.) and podiatrists (D.P.M.). The Board is responsible for setting policies and professional standards regarding the practice of medicine and podiatric medicine; considering applications for licensure; conducting examinations for licensure; investigating legitimate drug traffic among medical practitioners under the State's Uniform Controlled Substances Act; conducting hearings on disciplinary matters involving violations of the State's Medical Practice Act; and keeping up-to-date records on all licensed physicians, osteopathic physicians and podiatrists in the State.

The Board is composed of nine physicians (8 M.D.s and 1 D.O.) appointed by the Governor and meets bimonthly on the third Thursday beginning in January of each year.

The administrative functions of the Board are performed under the direction of its Executive Officer, P. Doyle Bradshaw, by eleven full-time staff members, including five investigators; one administrative assistant; one licensing officer, professional; one accountant, one secretary administrative, confidential and one secretary, principal. The office of the Board is located at 2688-D Insurance Center Drive, Jackson, Mississippi 39216.

LICENSURE DIVISION

Any physician, osteopathic physician, or podiatrist desiring to practice medicine in Mississippi must first obtain a license to do so by contacting the Board. When an inquiry concerning licensure is received, a questionnaire to elicit certain pertinent information is sent to the practitioner. Based upon the information given by the practitioner, a determination is made as to his/her eligibility for licensure. Names of references submitted on the questionnaire, as well as the American Medical, Osteopathic, or Podiatric Medical Associations; other states in which the practitioner has been licensed; and hospitals where the practitioner has held staff privileges are sent inquiries. If the information received is favorable, an application is sent to the physician.

During the year 1994, four hundred sixty two (462) **new** licenses were issued; seventy-one (71) **temporary** licenses were issued and seven (7) **limited institutional** licenses were issued.

During the year 1994, the board experienced an **increase** in four major functional areas of the Licensure Program as shown below:

Applications for licensure	39%
Written verification of licensure	62%
Certification of licensure to other states	14%
Renewal applications mailed	6%

During the fiscal year ending June 30, 1994, the board installed its own in house computer system and was able, for the first time, to process the annual renewal of physicians' licenses and to produce renewal wallet cards. The turn around time for mailing the wallet cards to the physicians was two days.

During the fiscal year ending June 30, 1994, the board processed six thousand, seven hundred forty seven (6,747) renewals. Various graphs, which indicate statistical information regarding physicians licensed by this agency, are attached. (See charts 3A through 3F for statistical information.)

3A — ACTIVE AND INACTIVE PHYSICIANS (MDs, DOs, DPMs) — FY 94 June 30

	In Mississippi	Out of State	All Licensees
Active			
Medical Doctors	3822	2327	6149
Osetopaths	122	48	170
Podiatrists	42	22	64
Total Active	3986	2397	6383
Inactive			
Medical Doctors	259	94	353
Osteopaths	3	1	4
Podiatrists	4	3	7
Total Inactive	266	98	364
Total all Physicians	4252	2495	6747

3B — ACTIVE PHYSICIANS BY RACE — FY 94 June 30

	In Mississippi	Out of State	All Licensees
White	3551	2155	5706
Black	236	121	354
Indian	2	2	4
Asian	183	117	300
Other	14	2	16

3C — ACTIVE PHYSICIANS BY SEX — FY 94 June 30

	In Mississippi	Out of State	All Licensees
Male	3462	2101	5563
Female	524	296	820

3D — ACTIVE PHYSICIANS BY AGE — FY 94 June 30

	In Mississippi	Out of State	All Licensees
34 and under	721	305	1026
35 - 44	1369	849	2218
45 - 54	908	696	1604
55 - 64	631	401	1032
65 and older	357	146	503

3E — NEW LICENSURE ISSUED 1990 - 1994 — FY 94 June 30

	1990	1991	1992	1993	1994
Licensure Issued	348	341	369	360	462

3F — LIMITED INSTUTIONAL LICENSURE 1990 - 1994 — FY 94 June 30

	1990	1991	1992	1993	1994
Limited Issued	1	7	11	14	7

With the increase in four major areas of the Licensure Division, and in an effort to expedite the licensure process, one Licensing Officer, Professional is being requested in fiscal year 1996 to assist with the increase being experienced by the Licensure Division.

INVESTIGATIVE DIVISION

Under the direction of the Medical Consultant, the Board's five investigators carry out the responsibilities of investigating alleged violations of the Medical Practice Act and the Mississippi Uniform Controlled Substances Act as it applies to medical practitioners.

The Investigative Division is also responsible for conducting Pharmacy Profiles. These Profiles are designed to determine if a physician is prescribing an unusually large quantity of drugs to a particular patient or if a patient is going from one physician to another for the same, or similar drugs.

In addition to Pharmacy Profiles, the investigators are responsible for looking into all substantial complaints and/or Practitioner Investigatory Reports (PIR) received concerning a particular physician. These investigations may include the screening of the physician for drug use.

During the year ending June 30, 1994, the board had an increase of forty one percent (41%) in complaints received.

The Board of Medical Licensure adopted a policy in July, 1992, requiring that each investigator be assigned an area of approximately twenty (20) to thirty (30) counties or a physician population of approximately 300 to 800. Currently the ratio of investigators to physician population is as follows:

Only Physicians with Mississippi Primary Practice, 1:1,117.

All Physicians Licensed by Mississippi, 1:1,750.

With a thirty-nine per cent (39%) increase in physicians licensed during 1994, the Investigative Division is in violation of its policy, as previously stated, in assigning an investigator to physician/county ratio. The agency is requesting an additional investigator for fiscal year 1996.

Various graphs are attached for your review of cases as performed by the Investigative Division of the Board of Medical Licensure. (See charts 5A and 5B for Case/Report information.) ❑

5A — INVESTIGATIVE DIVISION

NUMBER OF CASES
July 1, 1993 through June 30, 1994

Type of Cases	# of Cases
Prescribing	61
Impaired	5
Unprofessional Conduct	47
Illegal Practice of Medicine	5
Sexual Abuse of Patients	1
Inventory/Accountability	16
Other	9
Total Cases	144

5B — INVESTIGATIVE DIVISION

NUMBER OF COMPLAINTS/ PRACTITIONER INTELLIGENCE REPORTS
July 1, 1993 through June 30, 1994

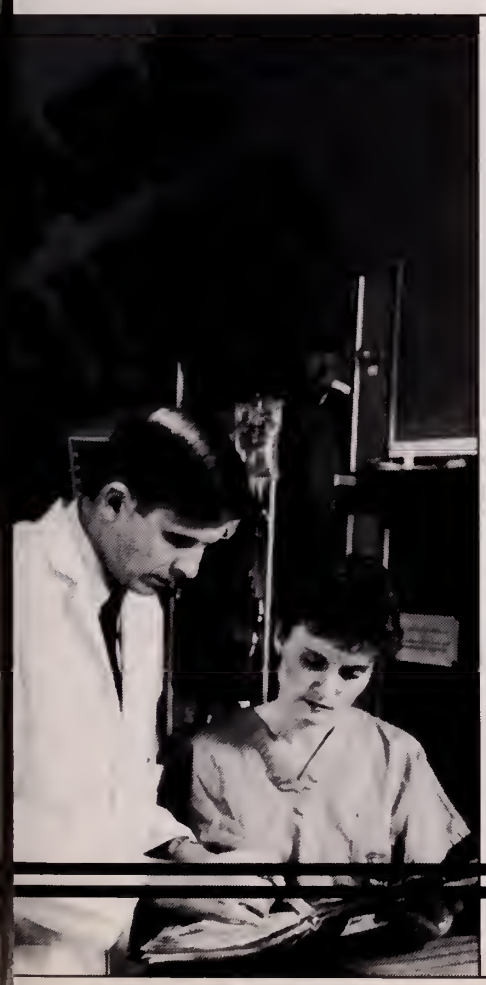
Type of Cases	# of Cases
Prescribing	58
Impaired	10
Unprofessional Conduct	82
Illegal Practice of Medicine	7
Sexual Abuse of Patients	2
Mental Illness	2
Inventory/Accountability	6
Other	49
Total Cases	216

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AIR FORCE



The President's Page

Mallan G. Morgan, MD

A New Year — A New Federation ?

Happy New Year!!

We have changed years and we are now in 1995. We are also seeing a change in the practice of medicine and we need to know where we are. We need to determine what we — and our patients — will expect from organized medicine in the next five to ten years. What will you want in the years ahead but haven't even thought about yet? And how should organized medicine be configured to meet those needs? These are the challenges posed by the Study of the Federation.

The two-year Study of the Federation involves a 214-member Consortium representing organized medicine — state, county and specialty societies, the AMA — plus key stakeholders such as the National Medical Assn., the American Osteopathic Assn., the American Medical Women's Assn. and Kaiser Permanente.

The Mississippi State Medical Association wants to be sure our voices are heard in the Federation Study. That's why Dr. John F. Lucas, III, of Greenwood is serving on the Consortium on behalf of you and your colleagues. Other Mississippians representing special interest in the Federation and serving on the Consortium are Drs. George E. McGee and Candace E. Keller of Hattiesburg.

This is a study *of* the Federation, *by* the Federation. The Consortium is designed to reflect the diversity of organized medicine — in age, gender, ethnicity, practice arrangement, specialty and type of medical association.

"The health system is reinventing itself," said Joseph T. Painter, MD, chair of the study. "By necessity, the major organizations and institutions related to health, including medical associations, must also reinvent themselves."

The Consortium first met on May 26, 1994, in Chicago. They used interactive software technology known as IRIS to evaluate what organized medicine should look like in the future. Some key issues identified: public credibility, responsiveness to diversity in the physician population, trustworthiness, financial stability, and the

(continued on page 20)

JOURNAL OF THE
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VOLUME XXXVI, NUMBER 1
JANUARY 1995

Mississippi Physician Supply— Shortage? or Surplus?

This summer the MSMA Council on Medical Service began studying nurse practitioners and the circumstances underlying their proliferation.

We learned that Mississippi has around sixty counties classified as "Health Professional Shortage Areas". We also learned that over the next ten years, 300 to 350 Mississippi family physicians will be needed to replace those lost through death, retirement and attrition and to meet current demands. Presently, our university graduates a maximum of fourteen family physicians per year.

Ronnie Boyd, Director of Primary Care Outreach with UMC Department of Family Medicine, related to us "The reason there is a strong demand for nurse practitioners is simply that there are not enough primary care physicians being trained. The rural communities are not just going to sit back and not have some type of health care professional in their town. If they cannot have a physician, then they will have nurse practitioners or some other mid-level provider. If physicians will not meet their health care needs, people are going to become advocates for nurse practitioners to expand their level of expertise and to practice more independently of physicians."

Mr. Boyd went on to say that "the MSMA should recognize the need to push the legislature to recognize the fact that there is a severe shortage of primary care physicians."

Please read his informative letter, which is reprinted in its' entirety, at the conclusion of this article.

Phil Macon, M.B.A., Practice Management Advisor with "Medical Business Consultants" wrote us that "From 1984 to 1991 the University of Mississippi Medical Center graduated an average of forty-four primary care physicians (Family Practitioners, Pediatricians, General Internal Medicine and Ob-Gyn) at a time when Federal guidelines indicated that there was a statewide shortage of 200+ primary care physicians. As a contrast Georgia produces almost forty Family Practitioners per year" (Remember we said earlier, UMC produces only fourteen.)

Macon continues, "Until we as a society adequately fund the training, compensation and continuance of medical practices in rural areas (doctors) will continue to locate into urban locations."

Our Council took this to heart, and at a subsequent meeting decided that it might make sense to recommend enlarging our in-coming medical school classes from its present level of 100 to about 125 students. (Remember only a few years ago, our classes numbered 150 students.)

At our most recent meeting we invited UMC Vice Chancellor Wallace Conerly to speak to the Council and address the role of the UMC in training primary care physicians, with an eye toward an enrollment increase being a potential means of easing the "primary health care provider" shortage.

Much to the surprise of the entire Council, Dr. Conerly prefaced his remarks to us by questioning our perception that there is a physician shortage in Mississippi and relating to us that the AMA was predicting a "physician glut" by the year 2000. Among many significant points made by Dr. Conerly were: (1) past Federal encouragement and funding resulted

(continued on page 18)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(Editorial continued from page 17)

in UMC increasing its enrollment to 150 students; (2) the current physical plant of the UMC would have to be enlarged above present levels for medical student enrollment to be increased; and (3) there is a difference of opinion among recognized authorities as to whether there is a shortage of physicians or a maldistribution of physicians. Dr. Conerly also concluded that three positive components for expanding medical school enrollment at the UMC would be: (1) strong support from the MSMA; (2) additional state funding; and (3) approval of accreditation agencies.

Numbers don't tell the whole story, geographic distribution of physicians is our biggest problem. Most doctors don't want to locate in extremely rural or inner city areas for exactly the same reasons that most other people don't.

Dr. Conerly says that medical students seem to have changed over the years, that as a whole they are much more money-oriented than in the past, and much less altruistic. He said that established physicians in practice have complained to him that virtually 100% of new physicians seeking employment or partnership ask not "how much good can I do for society, how many patients will I be seeing, or how much intellectual stimulation will I receive, but quite simply how much does the job pay?"

He related that in his day, it was simply assumed that a physician, regardless of his chosen specialty or locale, would automatically make a good living. What was unsaid was that these emerging physicians are today coming out of residencies with huge debt loads in tow and facing enormous start-up practice costs. This colors this issue a bit. Medical students today simply cannot always afford to be wholly altruistic beings. As we have all learned if we want the opportunity to practice our craft as "our calling", we still have to run it as a business. Where populations are primarily Medicare and Medicaid and the working uninsured, reimbursement does not always even cover overhead. If you only take care of very poor people, you may likely become poor as well.

Subsequent to this meeting the AMA House of Delegates met and among the agenda items were the subjects of nurse practitioners and physician supply and demand. The AMA News reports in this regard ". . . . Discomforting visions of a physician surplus and expanded roles for nurses were indeed at the top of many delegates' minds at the Interim (AMA) meeting. But rather than being panicked by the prospect, the House (of Delegates) took measured steps on supply questions with an eye to the long run. And even through delegates expressed alarm about nurse practitioners' drive for independent practice, they endorsed a plan to cooporate with nurses in a health care team and rejected calls for harsh measures against them.

"Encouraged by reports of a shift in medical student interest back to primary care, the House (did endorse) a variety of initatives to keep that trend going and encourage physician entry into underserved areas. The House called for:

- Special Medicare funding for residency training should be expanded to cover nonhospital sites, where there are more primary care experiences.
- State and primary care specialty societies should sponsor primary care internship for medical students on their summer breaks.
- Medical schools should build more ties with rural physicians, as a way of encouraging students to enter rural primary care practices."

MSMA members, help us out here: let the Council on Medical Service hear your feelings on this important subject. And do it soon. We'd like to form a consensus at our MSMA annual meeting in May.

Are we producing too many primary care physicians or not enough? What can we do to encourage more students into primary care fields and to get them out into communities where they are sorely needed? If we are doing such a wonderful job, why are physician surrogates suddenly multiplying exponentially? Please voice your perceptions.

Dwalia S. South, MD
Associate Editor

Dwalia South, M.D., Chairman
MSMA Council on Medical Service

Dear Doctor South:

I am the Outreach Coordinator for the Department of Family Medicine at the University of Mississippi Medical Center. Part of my responsibility is to help communities in Mississippi get in contact with our residents to tell them about their practice opportunity. Conversely, I work with the residents so that they are aware of all the practice opportunities in our State and will not be tempted to leave Mississippi in order to practice medicine. So I am better able to communicate to the residents the specifics about each practice opportunity, I go to each community and talk with community leaders, hospital administrators, and physicians about their

health care needs. I currently have about 100 practice opportunities in my files representing almost as many communities, and I have traveled to most of these sites.

As you may know, Mississippi has around 60 counties classified as Health Primary Shortage Areas. There is a need in Mississippi in the next ten years for about 300 to 350 family physicians. These numbers are needed to replace general and family medicine physicians who are over the age of 65 and to meet the current demand. Our program graduates a maximum of 14 family physicians a year and this will increase to 18 to 20 when the Tupelo program begins. Thus you can see that there is a severe shortage of family physicians in particular and primary care physicians in general.

The reason there is a strong demand for nurse practitioners and hopefully one day physician assistants is simply there are not enough primary care physicians being trained. The rural communities I have visited are not just going to sit back and not have some type of health care professional in their town. If they cannot have a physician, then they will have nurse practitioners or some other mid-level provider. If physicians will not meet their health care needs, people who are being provided health care by mid-level practitioners are going to become advocates for nurse practitioners to expand their level of expertise and to practice more independently of physicians.

The MSMA should recognize the need to push the legislature to recognize the fact that there is a severe shortage of primary care physicians, especially family physicians. Numerous states have innovative programs to increase the number of primary care physicians and to influence their choice of practice locations through various incentives. If there was an adequate supply of physicians in rural areas the increase in the demand for nurse practitioners would not be there. This is not to say that

Patient Relations and Telephone Skills

Central Medical Management, Inc., a Management Service Organization based in Jackson, announces a free workshop on **"Patient Relations and Telephone Skills"**, for physician office staff, practice managers and physicians.

This three hour presentation will be presented at the Gilfoy Auditorium at Mississippi Baptist Medical Center, on **Thursday, February 9, 1995, at 9:00 AM, and again at 1:00 PM.**

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(Editorial continued from page 19)

physicians should not be encouraged to work with mid-level providers especially in rural and underserved areas. Your concern about NPs and PAs being the sole provider will not be supported by the communities being served by them. After all, where are the physicians? They are not coming to my small community or rural area. Unless your committee comes up with specific solutions and suggestions to overcome this physician shortage, I believe the MSMA and your committee will be viewed as simply trying to maintain the status quo and protect physician turf and incomes.

If I can be of any help to you or your committee, please let me know.

Sincerely,
Ronnie Boyd, Director
Primary Care Outreach
Department of Family Medicine
May 25,1994

(President's Page continued from page 16)

ability to build strategic alliances.

Over the summer, outside consultants did field research based on the Consortium's findings. They held six focus groups, 13 on-site meetings with state, county and medical specialty societies, and 21 telephone interviews with leaders related to organized medicine. In September, a 30-member Project Team of Consortium members met to propose models for medical organizations of the future.

The Consortium reconvened October 1, 1994, in Chicago to review the research, and to discuss and evaluate the four models proposed by the Project Team.

The Consortium met again in Hawaii in December during the AMA interim meeting to test the models. Field research is on-going. The Consortium will meet three more times over the next 18 months. We will keep you up-to-date as the Study of the Federation continues.

Mal

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

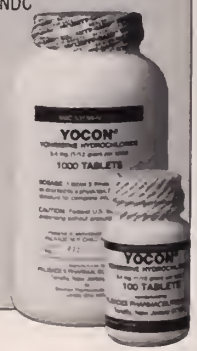
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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New Discount Programs Announced

MACM's Board of Directors approved several new discount programs during the December, 1994 meeting. According to R. Faser Triplett, MD, MACM President and Chairman, "We are pleased to offer discounts to loss free physicians and to physicians who participate in our risk management programs."

"Unlike our competition, MACM is structured to provide a service rather than make a profit, and we must carefully evaluate the amount of premium income necessary to provide the protection upon which so many Mississippi physicians depend," Triplett added. "For this reason, we will not engage in the unrealistic price wars and gimmicks other companies must use to entice physicians. What we can offer our insureds is a program which will have a positive impact on our bottom line by reducing losses through proactive risk management efforts, and one that will reward physicians who have been able to remain loss free in this hostile environment."

Physicians who meet the necessary requirements and who participate in approved risk management programs/workshops during 1995 will be eligible for discounts off their 1996 premiums. Schedules for the risk management workshops and seminars will be advertised and announced in future issues of the *MACM Monitor* and the *MSMA Journal*.

Loss Free Physician Discount

Physicians who have been loss free for five consecutive years as a MACM insured will receive a 5% discount off their standard premiums beginning in 1996. "Loss free" is defined as no indemnity payments and no outstanding claims or suits within that period of time. Incidents reported as a precaution will not exclude a physician from this discount program.

Large Clinic Retrospective Rating Program

Several options for potential savings for clinics with premiums of $200,000 or more were approved by the Board. The final premium paid by clinics participating in this program will be determined by the clinic's overall loss experience.

Risk Management Discounts

1. Hospital Based Program: MACM is working with MS Casualty Insurance Program's (MCIP) loss prevention staff to reduce liability risks for hospitals insured by MCIP and The Virginia Insurance Reciprocal, as well as the physicians who practice therein. MACM physicians who participate in these risk management programs in 1995 and who have at least 75% of their hospital admissions or consultations at a hospital insured by MCIP will qualify for a 10% premium discount beginning in 1996.

2. Clinic Based Program: Physicians participating in a MACM sponsored or approved workshop or seminar during 1995 will receive a 5% discount off their 1996 premiums. Program schedules will be announced as soon as they are finalized.



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Singing River Medical Society and South Mississippi Medical Society and Alliance Conduct Mini-Internship Programs

Singing River Medical Society and South Mississippi Medical Society and Alliance conducted Mini-Internship programs during 1994.

Singing River Medical Society held three two-day sessions with a total of twenty-four interns participating. South Mississippi Medical Society and Alliance held three one-day sessions with eight mini-intern participants.

Mini-Internship is the brainchild of Portland, Oregon psychiatrist Dr. Ralph Crawshaw. In the early 1970s, Dr. Crawshaw was a columnist for a prominent medical journal. He assumed the journal's editor had a strong clinical background, but was surprised to find his experience was solely in consumer publications. Since the editor had never spent time with a physician other than on a personal medical visit, Dr. Crawshaw arranged for him to spend several days observing doctors in hospital and office settings. The editor eagerly accepted the invitation to observe and became the first "mini-intern".

A Mini-Internship program could be called the ultimate community relations tool. It brings doctors and community opinion leaders together in a one-on-one setting, and offers an insider's view of medical professionals in action. This unique experience benefits the doctors, the interns, and the medical society.

Dr. Rick Whitlock, president of Singing River Medical Society, and Dr. George McGee, of South Mississippi Medical Society, both agree that their individual medical societies have greatly benefited from this program.

Singing River Medical Society's program selects interns from all areas of the community while South Mississippi Medical Society has concentrated more on legislators. The results of both programs have been the same, the "mini-interns" leave with a new image and better understanding of the medical profession and the physician participants have a renewed pride in their profession.

The Singing River Medical Society Program

Several years ago Dr. Roy Duncan, who was then president of the society, attended the AMA National Leadership Conference and heard about the Mini-Internship program. He brought the materials back to the society and began talking about the possibilities of setting up a Mini-Internship program. The program was discussed frequently during the year and when Dr. Rick Whitlock became president in 1994 the society was committed to try one session. "We went straight by the Mini-Internship manual", Dr. Whitlock said. "It tells you what to do every step of the way. We've had three programs this year and it's gotten easier each time."

The society members generated lists of potential interns. These interns were chosen and then invited by the medical society based on their position as decision makers in industry and government. When you consider some of the major industries located in the medical society's area such as International Paper, Chevron and Ingalls, you begin to realize the impact a program of this type could have. The potential intern list also included local and state legislators, representatives from the chambers of commerce, newspaper editors, media representatives, members of the Board of Supervisors, attorneys, hospital board members and other local business representatives.

The society also generated a list of society members who were willing to serve as the physician faculty and have interns "shadow" them on their daily schedule. The most obvious question asked by all physician faculty before the first program is, "what do I do with this person who is following me around?" The answer to this question is the real heart of the Mini-Internship program. You don't really **do** anything specific rather you **show** them. Just like the editor in Dr. Crawshaw's original program most mini-interns, even though they are opinion leaders in the community, are unfamiliar with all that goes on behind the scenes in the daily practice of medicine.

Singing River Medical Society's two-day program begins with a Sunday evening orientation meeting and dinner for both interns and physicians. The interns arrive first and have an opportunity to go over their schedules and ask questions. Dr. Whitlock said, "In addition to the basic program format and schedule, we now give each intern a list of helpful hints to make their time with us easier. For instance we suggest they wear comfortable shoes, eat a good breakfast, and that women leave their purses at home. Most of these suggestions came as recommendations from our first group of mini-interns." During this orientation session, each mini-intern is asked to sign a confidentiality agreement. The agreement simply states that the mini-intern recognizes the importance of preserving the integrity of the physician/patient relationship and that he will honor the confidentiality of each patient whose care and treatment he observes while participating in the program.

The physician faculty meets in a separate area to review the names of their mini-interns and agree on times and places to exchange interns during the program. At the conclusion of the briefing sessions, the interns and physicians meet together at dinner for the opportunity to get to know one another and confirm meeting times and places for the next morning.

Agreeing to participate in the Mini-Internship program demands a commitment from both interns and physicians. Singing River's Mini-Internship gets in full swing early Monday morning when the physician's schedule begins. Each intern has the opportunity to rotate through four or five distinct medical fields. Most mini-interns spend 1/2 day in Surgery, Emergency Medical Care, and Oncology and 1/2 day in a combination of Radiology and one other specialty such as Pediatrics, or Ophthalmology. On Tuesday afternoon, all mini-interns meet together to discuss their experiences in a debriefing session with a physician as the facilitator. The debriefing session is another key to a successful Mini-Internship program. This session allows the interns to "follow-up on their patients". Because interns rotate through several medical specialty areas during the two-day program, one intern might see the initial patient/physician consultation, another might see tests which were ordered for the patient and still another could possibly see a resulting surgical procedure. The debriefing discussion allows all mini-interns to see this continuity of patient care as they describe what they've seen over the last two days. The debriefing session also provides time for a verbal evaluation of the program allowing the interns to say the things they liked or didn't like as well as make suggestions for future programs. After the intern debriefing session the physician faculty joins the interns for dinner and a wrap-up session where the interns and physician discuss the experience and share impressions.

Dr. Whitlock said, "It cost about $3,000 for us to have one two-day session. This includes all of the postage, meals, printed materials and name tags for all participants. Our medical society secretary, Mrs. Lujean Trumble, spends a lot of time writing letters, making follow-up phone calls, arranging and rearranging schedules and setting up the dinners."

"A program such as this accomplishes many goals", Dr. Whitlock said. "Number one, it spotlights the patient/physician relationship. Number two, it opens valuable lines of communication and develops understanding between decision makers and the medical community. Number three, it stimulates a self-awareness among physicians to help identify problems and make improvements in the health care delivery system. This program is the best thing that's happened to our Medical Society in years."

The South Mississippi Medical Society and Alliance Program

The Mini-Internship program held in Hattiesburg is an Alliance project. In 1993 Natalie Morrissette, South Mississippi Medical Alliance Legislative Chairman, put together the first one-day Mini-Internship program. The program format was based on an Alliance program used successfully in another state.

Charlotte Townsend, 1994 Legislative Chairman, coordinated this year's program with a committee of five.

The Mini-Internship program was held three consecutive Mondays during November. This year's interns were mainly legislators but also included malpractice defense attorneys and a representative from Senator Trent Lott's office. Congressman Gene Taylor participated for his second year.

The Medical Society provided names of physician members interested in participating in the program and about 22 participated during the three one-day sessions.

Mini-interns spend the morning (1/2 day) with a physician in his office, the hospital or a combination of both. Then all the mini-interns meet together with several more physicians for a luncheon in the home of an Alliance member. After lunch the interns conclude their day by spending the afternoon (1/2 day) with

yet another physician in his office or the hospital. At the conclusion of the one-day session each participant, intern and physician, is sent an evaluation form.

Charlotte Townsend said, "We have had a wonderful response this year. Many of our interns have said as a result of this program they have a totally different perspective of what really goes on in the day-to-day practice of medicine. Some have asked to participate again next year."

The Alliance also invites members of the local media to participate in the Mini-Internship program both as mini-interns and to cover the program. They further offer to provide the media information to help them in reporting medical issues.

Dr. George McGee reported the success of these three one-day sessions to the MSMA Board of Trustees at it's November meeting. Dr. McGee said, "This is an excellent program which allows us the opportunity to let nonmedical people observe what we deal with on a daily basis. It's been great for everyone involved."

Singing River Medical Society and South Mississippi Medical Society and Alliance members have basically said the same thing about the Mini-Internship program. They both recognize that it takes a lot of commitment from everyone involved. It is time consuming to contact everyone by mail and follow-up phone calls. It is hectic during the days the interns are actually with the physician faculty keeping everything flowing smoothly. And, for the first time program, it is taking a big step on faith that everyone will see positive results.

The mini-internship is also one of the best programs for presenting the real life, day to day practice of medicine to lay people. It provides an opportunity for physicians to show and tell their side of the medical practice story. And most of all, the mini-internship provides an opportunity to make some new and lasting friends for medicine. ❑

Editor's note: As managing editor of your Journal, I would like to thank Dr. Whitlock, Mrs. Lufean Trumble and the member physicians of Singing River Medical Society for allowing me the opportunity to participate in their program. It was quite an education. Thank you!

MSMA Board Conducts Fall Meeting

MSMA's Board of Trustees and Officers held their regular Fall meeting in November and handled an extensive agenda to include reports from the MSMA Alliance and other medical organizations, a review of the association's legislative program, approval of a 1995 association budget and adoption of a 1995-1999 strategic plan.

Based on action by the Board the association's guiding mission statement in implementing its strategic plan for the next several years will be as follows: **"The Mississippi State Medical Association is a physician organization serving as an advocate for its members, their patients and the public health. The Association promotes ethical, educational and clinical standards for the medical profession and the enactment of just medical laws".**

In other actions the Board:

- Approved sponsorship of "A Patient Protection Act" by the association in the 1995 Mississippi Legislature.
- Approved joint sponsorship with the Mississippi Hospital Association of a Mississippi Hospital and Physician Foundation whose purpose will be to study and collaborate on health issues/projects. The Foundation Board will be composed of equal representation from MSMA and MHA.
- Approved 1995 operating budgets for MSMA, MSMA Diversified Services, the MSMA foundation and the MS Physicians Care Network.
- Reviewed 1995 MSMA membership recruitment plans and noted a net gain in 1994 MSMA membership. ❑

Medical Alliance and Society Raise $15,000 for Hospice

A gala event co-sponsored in October by the Singing River Medical Alliance and Singing River Medical Society raised $15,000 for the Hospice of Light, Singing River Hospital Systems' program geared to provide special care for the terminally ill.

"An Evening Under the Oaks," held October 18 at the Hull House of Beach Boulevard in Pascagoula, featured dinner by Jocelyn's, music by the band "Xcel" and a silent auction. Tents for the evening were provided by Jimmy Estabrook. Tickets for the invitation-only event were $100 per couple.

"The Medical Alliance wanted to organize an event that would benefit a local cause making an impact in Jackson County," said Alliance President Maura Whitlock. "Hospice of Light is a young program that is very much needed in our community. The Hospice staff has a list of items they would like to have in order to serve their patients more effectively."

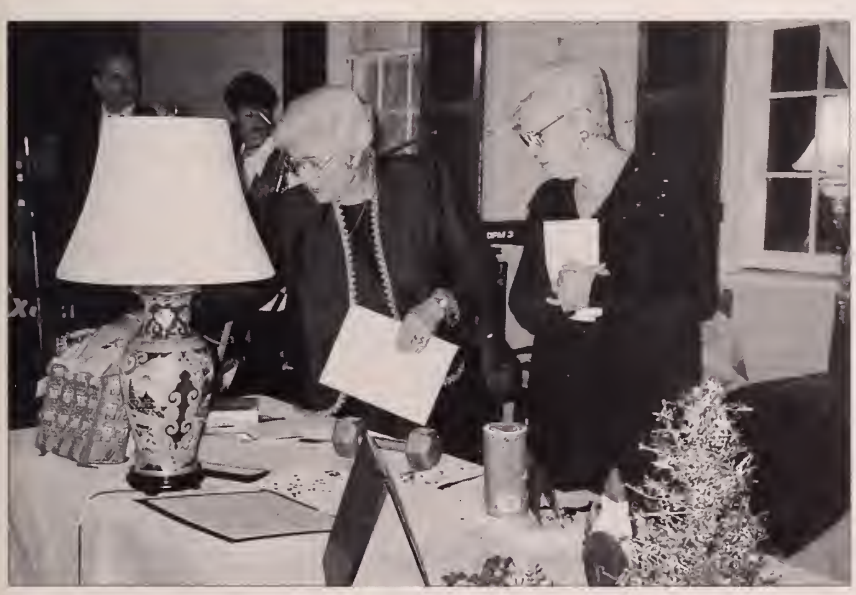


Among those attending "An Evening Under the Oaks", from left were, Marsha Avara, Suzanne Lyell, Melanie Moore, and Hal Moore, MD.

Those who worked to coordinate the event included: Food - Suzanne Lyell; Band - Rick Whitlock, MD; Invitations/Tickets - Lynn Duncan, Jean Moore, Maura Whitlock; Flowers - Regina Ehlert, Gale Singley, Emma Warden; Finance/Accounting - Suzie Mestayer, Roland Mestayer, MD, Mary Spencer, Lujean Trumble; and Silent Auction - Suzanne Lyell, Marsha Avara, Aimee Dugger, Peggy Hoover, and Regina Ehlert.

Hospice of Light first began accepting patients in March of 1994. Since that time, more than 50 patients have received treatment through the Hospice, which is licensed to provide care in all of Jackson County, eastern Harrison County, and southern George County.

The term "hospice" stems from medieval times when it was used to describe a place of shelter and rest for weary or sick travelers on long journeys, usually run by monastic religious orders. Today, the philosophy of hospice care relies on a team of physicians, nurses, social workers, clergy and volunteers to combine their various skills to help both the dying person and the family.



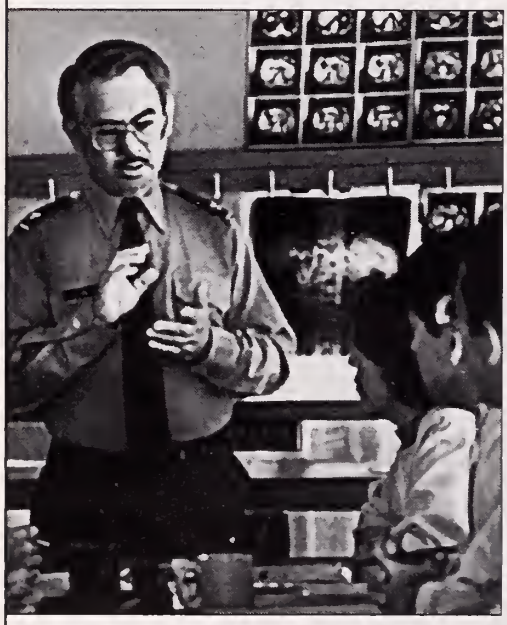
Browsing at the Silent Auction, from left, Jean Moore and Claudia Hollister.

The Hospice provides all the equipment and medication necessary for the dying person to be kept comfortable at home. The patient's attending physician and the Hospice staff plan a medical program that controls the symptoms and pain of the patient, while social workers, clergy and volunteers provide the emotional and spiritual support the patient and family need. Beyond the added emotional and clinical support hospice is the lessening of the financial burden of a prolonged illness. ❑



Attending the gala, from left, Edgar Hull, MD, Medical Director for Hospice; Laurie Grady, R.N., Hospice of Light Nurse Coordinator; and Maura Whitlock, President Singing River Medical Alliance.

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Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE
The MSMA provides a toll free WATS for any member to call to inquire about medical matters and programs of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

MEDICAL OFFICE SUPPLIES
MSMA members can save up to 40 percent on medical office supplies through "AMA Purchase Link". Under this program discounted medical, surgical and pharmaceutical products are available from Henry Schein, Inc., the largest nationwide distributor of such products to physicians' offices.

THIRD PARTY PAYOR LIAISON
MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE
MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

WORKERS' COMPENSATION INSURANCE
The MS Physicians Insurance Company (MPIC) is affiliated with MSMA and currently provides workers' compensation coverage to physicians' offices at the lowest rates available. MS law requires every employer with five or more employees to obtain such insurance. For further information contact Jennifer Corson at MPIC.

PRACTICE MANAGEMENT
Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

DEBT COLLECTION SERVICE
Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call MSMA.

INSURANCE/FINANCIAL/RETIREMENT PROGRAM
MSMA members have available several insurance plans designed exclusively for physicians. Through the "group" buying power of the association the plans can usually be obtained at lower cost and there is the advantage of "one stop" coverage. For further information contact Executive Planning Group.

MEDICAL MALPRACTICE INSURANCE
The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. The Company currently has 2000 policy holders. Extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-354-5433 or 800-898-0251 (In-State-WATS).

AMA Purchase Link - 800-772-4346.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company - P.O. Box 5229, Jackson, MS 39296-5229, 601-354-5433 or 800-898-0251 (In-State-WATS).

Medical Assurance Company of Mississippi - P.O. Box 4915, Jackson, MS 39296-4915, 601-353-2000 or 800-325-4172 (In -State-WATS).

Executive Planning Group, P. A. - 601-982-3000 or 800-898-0954 (In-state-WATS).

MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Services

When you need information on a specific subject or association service, the following MSMA staff person(s) are available to assist you.

Address Changes • Barbara Shelton

Advertising • Ginger Cocke

Annual Meeting:

- **Delegates** • Barbara Shelton
- **Scientific Exhibits** • Ginger Cocke
- **Technical Exhibits** • Dona Stevenson
- **Meeting Schedule** • Ginger Cocke

Bills and Invoices • Angela Martin

Board of Trustees & Officers • Charles Mathews

CommuniCare/Complaints from the Public/ Office Brochures • Lora Lane

Continuing Medical Education (CME) • Lora Lane

Component Medical Societies • Barbara Shelton

CPT/ICD-9 Inquiries • Debra Collins

Directories (MSMA and Alliance member listings) • Barbara Shelton

Dues (MSMA & Alliance) • Barbara Shelton

Government • Bill Roberts

Health Care Statistics and Data • Bill Roberts

Insurance Form Orders • Angela Martin

Journal MSMA • Ginger Cocke

Legislative Activities • Bill Roberts

Licensure • Bill Roberts

Mail Lists & Labels • Barbara Shelton

Media (Radio, TV, Press) • Ginger Cocke

Medical Ethics • Bill Roberts

Medical Student Membership • Barbara Shelton

Medicare/Medicaid/Third Party Payors • Jackye Wiebelt

Member Insurance Programs • Jackye Wiebelt

MMPAC/AMPAC • Bill Roberts

MS Physicians Care Network - Charles Mathews

Physician Referrals • Lora Lane

Practice Management Workshops • Debra Collins

Public Information • Ginger Cocke

Resident Physician Membership • Barbara Shelton

Scientific Assembly • Ginger Cocke

Young Physician Section • Bill Roberts

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Jackson, MS 39202
(601) 354-5433

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Jackson, MS 39296-5229
MS WATS (800) 898-0251

FAX: (601) 352-4834

Gene Barrett of Jackson was recently the guest speaker for the Mexican Arthroscopy and Knee Association. He was also the feature speaker on Newer Techniques in Meniscus Repair and Newer Techniques in Anterior Cruciate Ligament Reconstruction.

Nagen Bellare, of Hattiesburg has associated with **David M. Owen** in the practice of Hematology/ Oncology.

Richard Clark, of Hattiesburg, recently retired as off-line medical director of the Southeast Mississippi Air Ambulance District, a position he has held since the district's inception in 1971. The off-line medical director is responsible for the entire system and its protocol. A surgeon, Dr. Clark was instrumental in the development of SEMAAD, the longest running helicopter ambulance service in the country. **John Nelson**, a Hattiesburg emergency physician, will replace Dr. Clark. Dr. Nelson has served as on-line medical director for SEMAAD for 12 years, making him responsible for the day-to-day operations of the system and the personnel in the field.

John Clay of Meridian was elected president of the Southern Association for Oncology at the organization's recent annual meeting.

Marshall S. Ellis announces the opening of his office for the general practice of medicine, Westgate Center, 1015 Lee Drive, Clarksdale.

William B. Geissler of the University Medical Center in Jackson gave several presentations nationwide in 1994. He was co-author on *Arthroscopic Repair of Peripheral TFCC Tears* and *Arthroscopic Reduction of Greater Tuberosity Fractures* (Arthroscopy Assn. of North America, Orlando, FL). Presentations include *Management of Distal Radius Fractures* (AO Hand Course, Maui, HI); *Knee and Upper Extremity Injuries in Dancers* (Care of the Injured Dance Seminar, Jackson, MS); *Carpal Instability with Wrist Fractures* (AO/ASIF Advanced Hand Course, Telluride, CO); *Carpal Instability Associated with Displace Distal Radius Fractures* (Orthopaedic Trauma Association, Los Angeles, CA). Most recently he served as course faculty and presented *Arthroscopic Assisted Management of Intraarticular Distal Radius Fractures* (Wrist Arthroscopy Course, American Society for Surgery of the Hand, Birmingham, AL) and *Arthroscopic Reduction of Distal Radius Fractures* (Treatment of Common Wrist Problems, American Academy of Orthopaedic Surgeons, Rosemont, IL).

John P. Hey, III, a Family Practice physician with sub-specialty in Geriatric Medicine of Greenwood has recently been appointed by Governor Fordice to the Whitehouse Council on Aging. **Hal Liddell, Toxey Morris**, and **Nathan Shappley** announce the

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relocation of The Urology Center to Wesley Towers B, Suite 402, Methodist Hospital, 5003 Hardy Street, Hattiesburg.

Robert E. Lynch has been named Chief of Staff at the Jackson VA Medical Center. He replaces **Roland B. Robertson.** Dr. Lynch oversee all clinical, academic, and research programs at the medical center, which has 353 in patient beds, 120 nursing home beds, and provides 135,000 outpatient visits annually. The VA Medical Center has major teaching and research commitments through its close affiliation with the UMC School of Medicine, where Dr. Lynch is Associate Dean for VA Affairs.

A. Gordon Lyons, a partner with South Mississippi Anesthesia Associates in Hattiesburg, has accepted a fellowship position at the Baylor Center for Pain Medicine in Houston, Texas. Dr. Lyons plans to return to Mississippi in January 1996 after the completion of the one-year fellowship.

Robert D. McBroom announces the relocation of his office practice of Internal Medicine to 2101 Highway 90, Gautier.

Norman C. Nelson of Brandon has been inducted into the University of Mississippi's Alumni Hall of Fame.

James H. Sams of Columbus is now registered with the Food and Drug Administration as a Certified Clinical Investigator studying Chelation using EDTA and Hydrogen Peroxide (H_2O_2). Both Studies were accepted with IND numbers issued. There are approximately 75 centers participating in the ongoing long term study.

Buddy Savoie gave two presentations on Transglenoid Technique for Anterior and Multidirectional Instability at the AANA Fall Meeting in Palm Desert, CA. ❑

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Physicians' Recognition Award



Two MSMA members were named recipients of the AMA Physicians Recognition Award in November. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

North Central Medical Society
O. Lynn Hamblin, MD

Singing River Medical Society
William R. Ehlert, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

The *Journal MSMA Personals* Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office.

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Jackson, 853-5453
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Family/Er - Physicians needed immediately to staff our group of walk-in out-patient clinics. Paid malpractice insurance and no hospital call. Salary negotiable based on experience and efficiency. Bonus for pilots. Call Bobby Burle at (601) 335-7238 from 8 a.m. to 5 p.m. Monday thru Friday.

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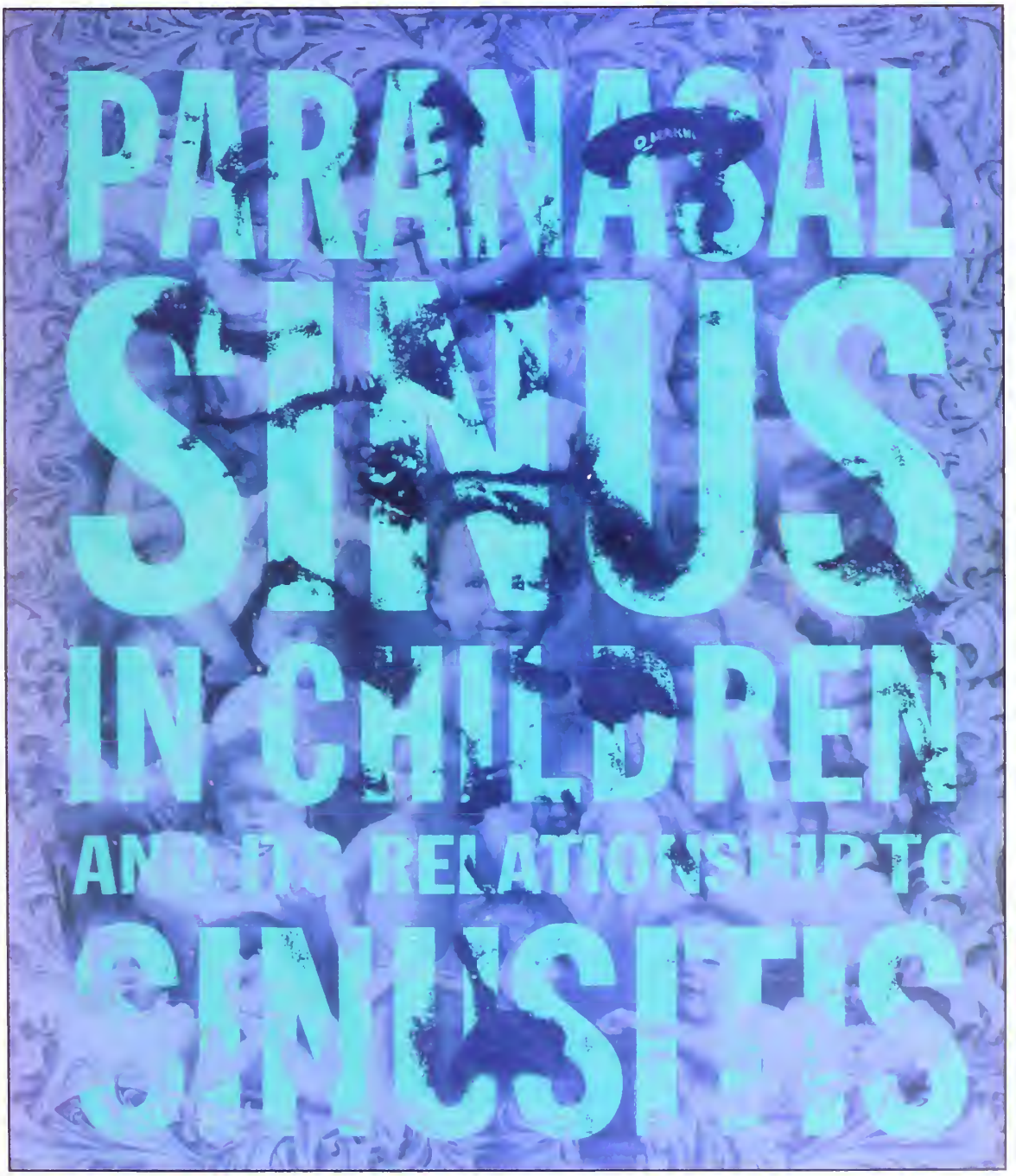
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Volume XXXVI, Number 2

Coding Workshop Schedule

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ICD-9 Diagnosis Codes - changes effective October 1994 & 1995

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DATES & LOCATIONS:

Monday, Feb. 27th	Tuesday, Feb. 28th	Wednesday, March 1st
Executive Inn	Holiday Inn S.W.	Holiday Inn
1001 N. Gloster	2649 Hwy. 80 W.	3400 Hwy. 49
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REGISTRATION INFORMATION:

Enrollment fee: $105.00 per member participant
$155.00 per non-member participant

The fee includes program, workbook, refreshment and lunch.

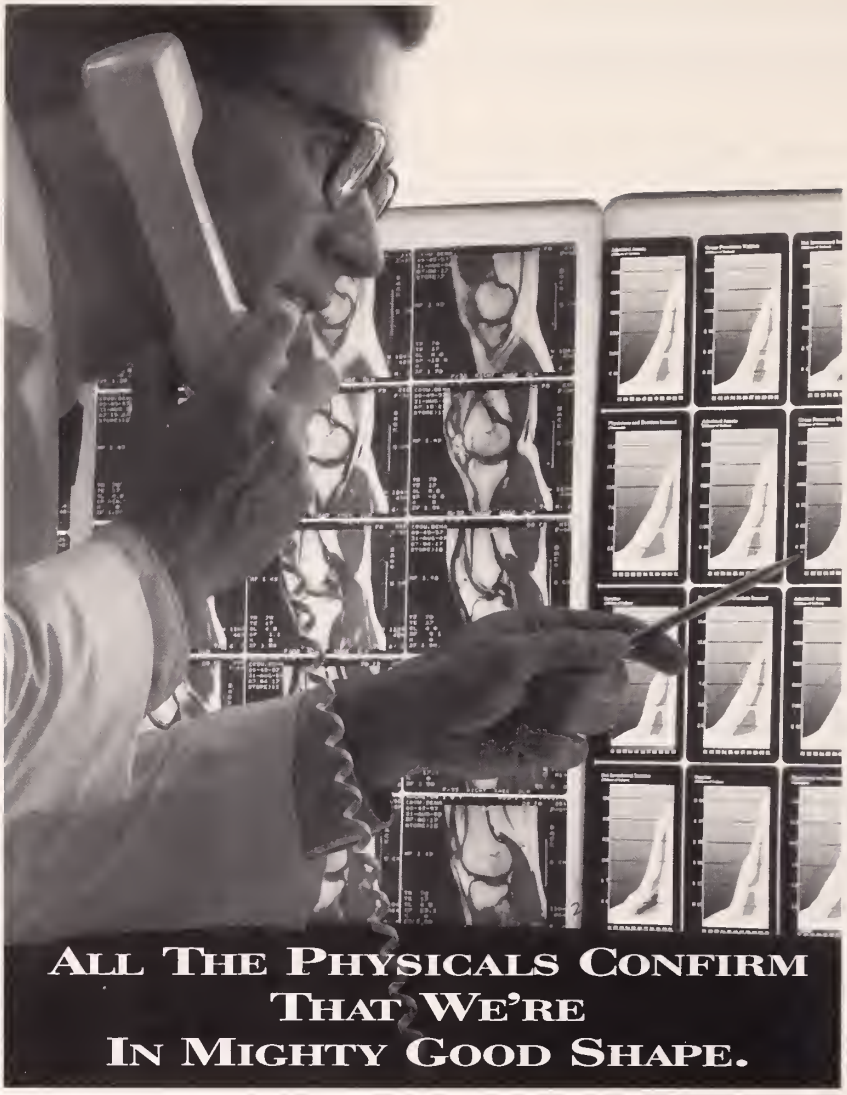
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127th Annual Session Scientific Exhibits

The MSMA 127th Annual Session will be held May 17-21, 1995 in Biloxi, Mississippi at the Treasure Bay Resort Hotel. Physicians who would like to reserve **Scientific Exhibit Space** should write: **Scientific Exhibits, MSMA, PO Box 5229, Jackson, MS 39296-5229** or Fax the following information to (601)352-4834.

The request for exhibit space should include:

(1) the title of the exhibit;
(2) the author(s) of the exhibit;
(3) an estimate of the amount of exhibit space needed (MSMA will provide a table only - all other materials are the responsibility of the exhibitor); and
(4) a brief synopsis of the subject to be exhibited.



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Onychomycosis Update

Carlton M. Daniel
Melissa P. Daniel, MCS, CTASCP
C. Ralph Daniel, III, MD

The term onychomycosis means any fungus infection of the nail. Tinea unguium is defined as a dermatophyte infection of the nails. Dermatophytes are the most common fungi that act as primary pathogens of the nail. Trichophyton rubrum and Trichophyton mentagrophytes are still the most common dermatophytes that cause tinea unguium.[1] Nondermatophyte fungi as Hendersonula torolodea and Scopulariopsis brevicaulis are uncommon causes of onychomycosis.

It appears that the tendency to get tinea unguium may be inherited in an autosomal dominant fashion with incomplete penetrance. There does seem to be a possible selective T-cell defect causing nonrecognition of the dermatophyte.[2] Individuals that develop tinea unguium usually first manifest tinea pedis. Then the seal between the nail plate and nail bed is broken (often by trauma) allowing the organism to become entrenched in the nail bed. In most cases of tinea unguium, the nail bed is the primary site of pathology, not the nail plate. Only in a small minority of patients is the nail plate the primary site of pathology (superficial white onychomycosis—see below). We are still finding that children uncommonly manifest the disorder. The same is true for normally menstruating women. This goes along with the general observation that as an individual ages, that person is more likely to manifest onychomycosis.

Onychomycosis may be divided into several categories:[3]

1) Distal subungual onychomycosis — This is the most common. In this case, the organism initially penetrates the nail in the area of the hyponychium or distal lateral nail fold.

2) Superficial white onychomycosis — In this disorder, the fungus initially penetrates the nail plate rather than in the nail bed. The disorder is rare in the fingernails of healthy nonimmunocompromised individuals. The most common causative organism is Trichophyton mentagrophytes.

3) Proximal subungual onychomycosis — This is the least most common presentation. In this case, the organism initially penetrates the nail unit in the region of the cuticle.

The gold standard for diagnosis of onychomycosis is still the potassium hydroxide stain and fungal culture.[4] It is best to culture the organism on plain Sabarauds agar with chloramphenicol as well as Sabarauds agar with chloramphenicol and cycloheximide. The chloramphenicol inhibits growth of bacteria and the cycloheximide inhibits the growth of most nondermatophyte fungi.

It is best not to use dermatophyte test medium for cultures of the nails for several reasons:[4]

1) Observation of gross thal-

lus morphology and color are hindered by the red color change that may occur with use of this medium.

2) Scopulariopsis, and some saprophytes including species of Aspergillus, Penicillium, black molds, and yeast may also cause a color change thus giving a false-positive reaction.

A single positive potassium hydroxide stain may certainly suggest a fungus, but a negative one alone does not rule out a fungus.

Multiple potassium hydroxide stains and fungal cultures should be performed before the suspect nail is considered not to be onychomycotic.

Clinical impression alone is not adequate to diagnose onychomycosis when systemic therapy is planned.

Onychomycosis is common in patients with HIV disease.[6] Indeed, the presence of onychomycosis has been helpful in classifying patients with HIV disease because it generally correlates with helper T-cell numbers less than 100 cells/mm^3. [6,7] The causative organisms and clinical appearance are usually similar to patients without HIV disease, but there are some important differences.[8]

1) A proximal white subungual onychomycosis often appears.[6,8] This is unusual in the general population.

2) In nonimmunosuppressed persons, chalky white involvement of the outer nail plate (superficial white onychomycosis) is rare in fingernails and is usually caused by Trichophyton mentagrophytes.[5] In HIV infected persons, this presentation is not rare in fingernails or toenails and is usually caused by Trichophyton rubrum.[6,9]

3) Unlike classical onychomycosis, the disorder may spread rapidly to all the fingernails and toenails.[6]

4) It is rare in the general population to see dermatophyte infection of all ten fingernails concomitantly. This is not rare in HIV-positive patients.

5) The periungual region may be involved with the dermatophyte infection.[7] This is unusual in the general population.

6) It is rare for Candida to be a primary pathogen that directly invades the nail plate of a healthy person.[8] However, Candida nail dystrophies are common in HIV positive patients, especially when the helper T-cell count is less than 100 cells/mm^3.[6,7] Candida albicans is the major fungal agent in pediatric acquired immunodeficiency syndrome (AIDS).[10] Chronic candidal paronychia seems to occur most commonly between the ages of 2 and 6 years and is sometimes associated with severe nail dystrophy.[11]

To be efficacious, systemic antifungal therapy must be instituted to reliably treat tinea unguium. Although there are no hard statistics, treatment with systemic ketoconazole or griseofulvin clear fingernails about 60% of the time and toenails about 20-30%. Relapse is the rule. To date, topical therapy has not been shown to reliably clear tinea unguium. One of us has completed two studies utilizing topical antifungals which were not efficacious. He is presently testing a different topical antifungal. Due to the lack of ability to penetrate the nail plate to the nail bed (where most of the organism usually resides) older topical preparations have not been efficacious.

Itraconazole and fluconazole are not FDA approved for treating tinea unguium but they are both available in the pharmacy. One of the authors has used both of these systemic drugs with much better results than systemic griseofulvin or ketoconazole. Most investigational regimens utilizing these two newer drugs have been used as pulse or intermittent therapy. The evidence is mounting that these two drugs may have a depot effect, thus necessitating giving the drugs for a shorter period of time than ketoconazole or griseofulvin. In addition, although itraconazole and fluconazole may have a number of drug interactions with other drugs, the side effects have seemed to be less than with griseofulvin or ketoconazole. One of the authors is presently testing terbenifine systemically, in a double blind fashion.

The future seems to be brighter for treating onychomycosis. The newer systemic drugs seem to be more efficacious with less side effects. Also, there are some new topical preparations being tested that hold promise. ❑

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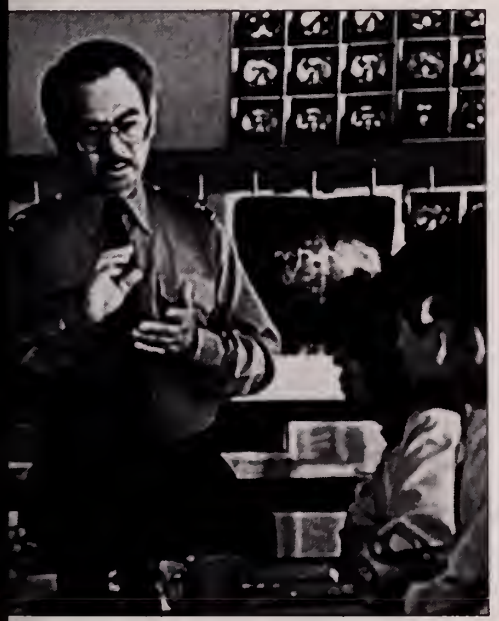
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Paranasal Sinus Development In Children and Its Relationship To Sinusitis

C. Ron Cannon, MD
Barry McCay, MD
James R. Haltom, MD

Sinusitis has become a more commonly recognized problem in children. The symptoms of sinusitis in children are protean. The most common symptom, particularly in young children is that of anterior purulent rhinorrhea. Other symptoms are those of purulent post nasal discharge, cough, nasal obstruction, and rarely facial pain. The mainstay of treatment is medical therapy although recent studies have indicated that sinus surgery is beneficial in selected patients.[1-3] The recognition of sinus disease in children has been facilitated by application of endoscopic techniques and CT scanning first used in adults.

The location of the sinuses and density of bone in a child's face renders physical examination by techniques such as transillumination virtually useless. Radiographic examination, therefore, is the cornerstone of diagnosis of sinusitis in children. Previously, plain films have been utilized although not without controversy. Some authors have indicated that sinus opacification is not a reliable index for the diagnosis of sinusitis in young infants.[4] In children more than one year of age, however, an abnormal sinus radiograph is felt to be a reliable indicator of inflammation.[5] Kovatch et al reported abnormal sinus films in 50% of asymptomatic patients less than one year of age, above that age; however, only 7% of asymptomatic children had abnormal sinus films.[5] These investigations indicate that plain sinus films must be interpreted in the light of clinical findings.[6]

Due to the limitations of plain sinus films, the CT scan has been used as a method to better evaluate sinus disease in children. Although the CT scan has broadened our knowledge of sinus disease in children, there are still many unanswered questions. Even such basic questions as the developmental schema of sinus aeration and the patterns of mucosal abnormality remain unclear. The current study was undertaken to help answer these questions and also investigate other anatomic considerations that might influence sinus disease in children.

METHODS

A study protocol was developed to study the aeration, mucosal abnormalities, development of the ostiomeatal complex, and other abnormalities of the nose and sinuses in children. Patients aged 1-15 years who were referred for evaluation of sinusitis were enrolled in the study group. Each patient had a CT scan obtained in a coronal projection without contrast using 3 mm cuts through the nose and sinuses. Children under the age of three usually required sedation prior to the scan. A single radiologist interpreted all scans.

The study was terminated when 100 patients were enrolled in the study protocol.

RESULTS

The patients were arbitrarily divided into three groups, ages 1-5, 6-10, 11-15 years. The demographics of the study group are depicted in Table 1.

The development of the sinuses was determined for each age group. In Group I ages (1-5) the maxillary and ethmoid sinuses were noted to be present in the vast majority of patients (Figure 1). Whereas the sphenoid and frontal sinuses were present in

Table I — Group Demographics
N= 100

Group I	**Age 1 - 5**	**N = 40**
Group II	**Age 6 - 10**	**N = 37**
Group III	**Age 11 - 15**	**N = 23**

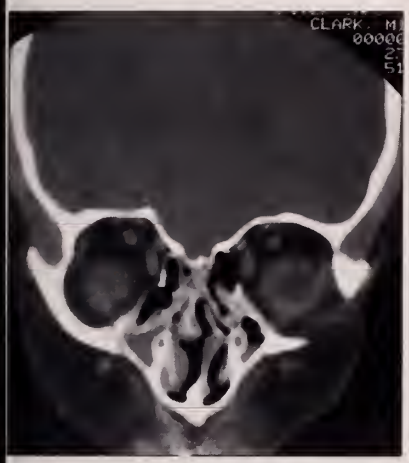


Figure 1: A young child demonstrating also maxillary and ethmoid sinusitis. Note also the occluded ostiomeatal complex (arrow).

only a few patients. In Groups II (ages 6-10) and III (ages 11-15), the maxillary and ethmoid sinuses were present in all patients. In Group II the sphenoid sinuses were present in 92%, while the frontal sinuses were present in roughly half the patients. In Group III the frontal sinuses were present in about 70% of patients (Figure 2). There were no significant differences from side-to-side in any of the three groups. (Table II).

The degree of mucosal thickening for each of the sinuses was measured (Table III). Air-fluid levels within the maxillary sinus were identified infrequently. They were found in only one patient in the youngest age group. Air-fluid levels were seen in 9% of the intermediate age groups and 11% of the oldest age group. The low incidence of air-fluid levels probably represents the chronicity of the sinus complaints in the study group.

The height of the dome of the ethmoid was compared to the adjacent orbit. In Group I the dome extended to the middle-third of the orbit in the majority of patients, while in the other two groups, the dome of the ethmoid extended to the level of the superior orbit.

Table II — Development of Sinuses

	Maxillary		Ethmoid		Sphenoid		Frontal	
Patient/Side	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**
Group I	90%	88%	90%	88%	18%	18%	3%	3%
Group II	100%	100%	100%	100%	92%	92%	48%	54%
Group III	100%	100%	100%	100%	96%	96%	74%	65%

Table III — Mucosal Hypertrophy

	Maxillary	Ethmoid	Sphenoid	Frontal
Group I	63%	53%	8%	3%
Group II	56%	53%	19%	12%
Group III	55%	50%	24%	9%



Figure 2: An older patient demonstrating development of the frontal sinuses.

The ostiomeatal complex is the primary drainage pathway for the anterior ethmoid air cells as well as the maxillary and frontal sinuses. In Group I the ostiomeatal complex was obstructed unilaterally or bilaterally in 60% of patients. In Group II the complex was obstructed in 52% on the right side, and 43% on the left. In Group III the complex was blocked in 48% of patients either singly or bilaterally.

In an attempt to quantitate abnormalities of the nose which cause clinical symptoms, a separate limb of the study protocol dealt with the presence of nasal septal deviation, turbinate hypertrophy, or pneumatization of the middle turbinate (concha bullosa). In Group I only two patients were noted to have a deviated septum. In Group II a deviated septum was noted in 16% of patients, and in Group III 35% of patients had a



Figure 3: Nasal septal deviation (arrow) noted on CT scan.



Figure 4: A concha bullosa, aeration of the middle turbinate (arrow).

deviated septum (Figure 3 and Table IV). Turbinate hypertrophy was defined as an inferior turbinate obstructing > 50% of the nasal airway. In Group I turbinate hypertrophy was identified in 32% of the CT scans examined. In Group II 52% had turbinate hypertrophy, while in Group III 59% had turbinate hypertrophy. Pneumatization of the middle turbinates was noted in only 3% of patients less than age 5, 4% of patients less than 10 years, and in 11% of patients more than 10 Years of age (Figure 4).

Table IV — Ancillary Nasal Findings

	Deviated Septum	Turbinate Hypertrophy	Concha Bullosa
Group I	63%	53%	8%
Group II	56%	53%	19%
Group III	55%	50%	24%

COMMENT

There is some discussion about the stages of sinus development by various authors. The sinuses become apparent by the beginning of the third to fifth month of intrauterine life.[7] At birth the ethmoid sinuses are almost fully developed while the maxillary sinuses are slit-like evaginations in the lateral nasal wall[8-9] Goldenkersh et al feel that the frontal sinuses develop earlier than do the sphenoid sinuses.[7] The results of the present study verify that the ethmoid and maxillary sinuses are the first to be apparent. However, the degree of pneumatization of the maxillary sinuses may be greater than previously thought in young children. Our study also indicates that the sphenoid sinuses develop prior to frontal sinus development. An example of the clinical implications of these findings relate to patterns of pain. For example, complaints of a vertex headache may be more suggestive of sinusitis than are frontal headaches in children. This may also explain the low incidence in children of intracranial complications due to frontal sinusitis.

Mucosal thickening was consistently noted in the maxillary and ethmoid sinuses. In the older age groups the sphenoid and frontal sinuses were involved more frequently. It appears that maxillary and ethmoid sinus disease is frequently related to occlusion of the ostiomeatal complex and subsequent secondary infection of the sinuses.

In patients less than age 5, the dome of the ethmoid sinus extends only to the mid-third of the orbit in 68% of the patients. This finding should alert the surgeon to limit dissection superiorly in the region of the roof of the ethmoid to avoid damage to the anterior cranial fossa and subsequently a spinal fluid leak.

Other ancillary findings were also noted. Only 5% of patients in Group I had a deviated septum, while 35% of patients in Group III were noted to have a deviated septum. It is not known whether a deviated septum is a congenital or acquired abnormality. This study suggests that a deviated septum may be an acquired abnormality. Turbinate hypertrophy as a cause of nasal obstruction was also noted more frequently in the older age groups. Concha Bullosa has been statistically linked to the development of sinusitis.[10] In the study group a concha bullosa was identified infrequently in Groups I (3%) and II (4%). In Group III the incidence of a concha bullosa was 11%. Pneumatization of the middle turbinate has been thought to be an outgrowth of the ethmoid air cells. If so, the pneumatization takes place independently of the ethmoid system and at a slow rate of development.

SUMMARY

A study of CT scans in 100 patients aged 15 or less has indi-

cated the following:

1. The ethmoid and maxillary sinuses are the first to develop, followed by the sphenoid sinus, and lastly the frontal sinus.

2. Mucosal abnormalities in all of the studied age groups indicated greatest involvement in the maxillary and ethmoid sinuses.

3. In children less than five years of age the dome of the ethmoid generally extends only to the middle third of the orbit. In operative procedures involving the ethmoid sinus, care must be taken to avoid damage to the roof of the ethmoid and hence any CSF leak.

4. Ancillary findings such as septal deviation, turbinate hypertrophy, and concha bullosa occur with increasing frequency in older patients. Thus, in older patients concomitant problems such as a septal spur or a concha bullosa impinging in the middle meatus should be sought as a contributing etiology of sinusitis. ❑

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The President's Page

Mallan G. Morgan, MD

I Love You & Happy Valentine's Day

We all know that there are many kinds of love and most of us have experienced most of these: love of God, love of our spouse or significant other, love of our children, parents, brothers and sisters. We love our friends and, I believe, our patients. I think most physicians truly love their patients and this is what enables us to care for them on weekends, in the middle of the night, or when we interrupt something we may have looked forward to for a long time. Perhaps its this love of people that attracts us to others that feel the same way. These people are our spouses and they have banded together to form the Mississippi State Medical Association Alliance.

This love for others has guided the Alliance to undertake several projects for the state this year. They have continued their support of the Health Choice Program for the youth of Mississippi and have even expanded to five locations in 1995. They have continued their support of AMA-ERF to help educate the physicians of tomorrow. They have already made seven presentations to local alliances and other medical groups on the Impaired Physicians Program. The Alliance is also working on the Clothes Line Project which encourages victims of domestic violence to break the pattern of abuse and obtain help.

As if that were not enough, several component society Alliances have had their own projects, for which they have even received recognition on a national level. The Hattiesburg Alliance held the largest bone marrow drive in the United States and are planning a children's immunization drive this year for Doctor's day. They also support their local Domestic Abuse Shelter and mini-internship program. Central's Alliance, not to be outdone, received the 1994 AMA Alliance Health Promotions Award for their work with the Blake Clinic, raising $15,000 for the clinic. In Pascagoula, the Singing River Alliance raised $15,000 for the "Hospice of Light", Singing River Hospital's

(continued on page 46)

JOURNAL OF THE
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My Right Arm Is Pregnant

Months ago, in one of the hideous nights of my life, a vision sent me thrashing in the middle of an exhausted sleep. Horrifyingly, my long time trusted aide, with me almost since my shingle first creaked on its hinges, was leaving. Now, certainly we are the captains of the health care ship and the masters in the hospitals, but this was Cathy—Cathy who hires for me, straightens my books, and steers me through CLIA, COBRA, HCFA and OSHA.

Sweating, I bolted up with a fearful grunt, then realized through deep breaths that it was all a dream. The relief, however, was only temporary, for I've developed over the years a great respect for dreams. Dreams are our unconscious knowledges. They are our primordial fears, percolating from the id up into our awareness. With a nervous laugh I told Cathy the next day of the silly episode, then watched her expression change. I learned now that ten days earlier she had taken the notion she might be pregnant. She hadn't yet tried a pregnancy test, afraid to get her and her husband's hopes up for something that had been waited on and hoped for for fifteen years. If I dreamed it it must be true, I said, happy for her but feeling my grip slipping at the prospect of a prolonged maternity leave. And sure enough, it was true, confirmed by a drug store test she purchased on the way home that evening. Within a month she began to swell.

We doctors feel so self reliant we forget how reliant we are—on others, that is. Some time back we could leave a house on which we had called, climb into the buggy and relax for the next fifteen minutes, mesmerized by a horse's swaying backside while heading to the next call. Now we are out of one room and into another. The phones and messages and families and prescriptions are incessant. We juggle three oranges in front of ourselves and two more behind. How attached we become to those loyal souls who smooth our way through this world.

My right arm grows heavier with each passing month. Cathy moves ponderously now with a look of happy fatigue. My messages still come just so, interruptions for the vital, the others placed in their proper holding pattern. The patients are still treated with a firm sort of grace. But how long will that last? Will a temporary aide have the same deft touch? Can I count on her to remember the things I forget? No. Familiarity, loyalty and trust develop over a period of years.

Let us remember we do nothing by ourselves. We are part of a team, a system, the effectiveness of which has a great deal to do with how well we as doctors respect and mesh with the other members. As for me, tell me three times that no one is irreplaceable. Only on the third will I hear, though not believe a word of it. My right arm, you see, is pregnant.

Leslie England, MD
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(President's Page continued from page 44)

program geared to provide special care for the terminally ill. This list of projects doesn't even include what the Alliance has done with their Phone Bank which responds so well to our requests for communicating our position on legislative matters, elections, etc. Mrs. Karen Stephens, the President of the MSMA Alliance, and her fellow members, through the activities chronicled here, have truly shown their love for all the people of Mississippi and are making this a better place for all of us to live.

Franklin P. Jones once said, "Love doesn't make the world go 'round. Love is what makes the ride worthwhile." The members of the Alliance are not only nice to cuddle up to at home but have extended the love that they have shown us, their physician spouses, to all the people of Mississippi and we are all the richer for it. So, it is with honest emotion that I say to all of the members of the Alliance, "I Love You and Happy Valentine's Day."

Mal

P.S. Happy Valentine's Day, Darlin'. I Love You.



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AIR FORCE

The Variation Phenomenon

Alton B. Cobb, MD, MPH

Many studies from the United States and other countries have shown wide variations between hospitals and geographical areas in health services provided to patients with the same diagnosis or condition. These observations of practice pattern variations are often referred to as *The Variation Phenomenon.*

Some of these variations are due to differences in case-mix of patients from one hospital or geographical area to another hospital or area. Patients may be sicker in one locality than in another; however, many of these variations are not easily explained by case-mix differences. If the patients have similar characteristics which may influence their illness or potential for recovery, and medicine is founded on a strong science basis, it is difficult to explain why such wide variations exist.

One of the principal goals of The Health Care Quality Improvement Program (HCQIP) is to study such variations in practice patterns involving conditions or procedures for which a clinical guideline exists.

Hospitals and their medical staffs are actively engaged by the PRO in analysis of these patterns with the goal of identifying opportunities to narrow some variations as well as the overall goal of effectively utilizing resources to improve quality of care and outcomes.

A current HCQIP project is analyzing blood transfusion practices in Medicare patients undergoing hip replacements, open reductions for hip fractures (ORIF) and knee replacements. Three hospitals are participating in this study which includes 397 cases for these three diagnoses. Several interesting variations in the use of blood and alternative therapies have been observed.

Among the 88 cases having ORIF procedures, the rate or percentage of patients receiving blood transfusion varied among the three hospitals, from a low of 30% in one facility to a high of 60% in another. Even greater variations were observed for hip replacement procedures, from 12% to 50% and from 12% to 70% for knee replacement procedures. (The use of reinfusion devices offset in part the variation for knee procedures).

Each hospital involved in the blood transfusion project will be presented with these pattern variations. The PRO will request that each hospital evaluate their transfusion practices using as a guide, **Practice Strategies for Elective Red Blood Cell Transfusion**, published by the American College of Physicians. The goal of quality improvement will be effected by the development of an improvement plan with subsequent measurement of results.

To receive a copy of the American College of Physicians' **Practice Strategies for Elective Red Blood Cell Transfusion**, write to: Attn. Belinda Moseley, Mississippi Foundation for Medical Care, Post Office Box 4665, Jackson, MS 39296-4665, or call Ms. Moseley at (601) 948-8894.

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Risk Management Alert: Ambiguous Radiological and Surgical Reports

There appears to be some evidence that the right kidney could be abnormal, but it may be normal. Stones may or may not be present in the right kidney. The pelvis does not appear thickened in most areas, although one area measures abnormally thick. This is probably not a real finding.

While this example may appear to be extreme, similar wording has begun to surface frequently in radiology and pathology reports. It is obvious that this litigious environment in which physicians must practice has forced all health care providers to place more emphasis on defensive medicine.

Radiologists and Surgeons: It would be helpful if standard and consistent terms could be used in describing findings. Terms like "busy breast pathology" are of little use to OBs or Family Practitioners. Always communicate any abnormal findings.

Primary Care Providers: If you order a study, be sure to communicate to the specialist what you want to know.

For reports that are noncommittal, take time to communicate with your Radiologist and/or Surgeon. Call and ask for an oral explanation of the report, which you should document in the chart, or ask for an addendum or supplementary report. The purpose of this call is not to ask for an opinion of how to treat your patient, but rather to clarify what the report means.

Mammograms: Of particular concern now are the failure to diagnose allegations related to mammography. Ten to 12% of carcinomas of the breast do not show up as abnormalities on a mammogram; therefore, it is imperative that patients with a dominant breast mass obtain surgical consultation, regardless of the outcome of a mammographic examination. To observe patients with breast masses and "normal" mammograms is very dangerous.

The wording in mammogram reports can seem to imply pathologic information, but this is only the Radiologist's opinion. If abnormalities appear that are suggestive of a malignant process or if changes from previous mammographic studies are recorded, surgical consultation should be obtained.

According to local experts, any adequate mammogram report should end with one of the following recommendations:

1. **Normal: Recommend yearly follow-up.**
2. **Mildly suspicious: Recommend short-term follow-up.**
3. **Suspicious: Recommend biopsy.**

The U.S. Department of Health and Human Services has published an excellent mammography guide for clinicians. You can call 1-800-358-9295 for a free copy.



Luncheon Speaker, Fred Barnes, senior editor of the New Republic.



Michael Dunn speaking on grassroots political action.



Rick Whitlock, MD, Immediate Past President Singing River Medical Society.

Mississippi Hospital and Physicians Foundation Legislative Program Held January 17

The Mississippi Hospital and Physicians Foundation Joint Legislative Forum and Reception was has held, January 17 at the Ramada Coliseum in Jackson.

The session began with Peter F. Straley, Vice President, Jennings Ryan & Kolb of Northampton, Massachusetts presenting an interesting and somewhat overwhelming program entitled *Transitioning to a Capitated System*.

Fred Barnes, senior editor of the *New Republic*, was the luncheon speaker. Mr. Barnes is a nationally known political commentator who serves as the conservative voice at his magazine where he has a regular column on the presidency ("White House Watch") and writes about politics and the media. Mr. Barnes presented his views on the current Congress and future presidential candidates.

The afternoon session began with Michael Dunn, president, Michael Dunn and Associates in Washington, D.C. Mr. Dunn, who has spoken at past the Legislative Forums, discussed, "The Political Environment for Health Care— Why Grassroots Political Action is Necessary".

As an example of a grassroots educational program, Singing River Medical Society Immediate Past President, Dr. Rick Whitlock presented an overview of their "Mini-Internship Program." Mississippi Representatives Carmel Wells-Smith and Billy Broomfield discussed their impressions of the Mini-Internship. Both Representatives were participants in Sing-



MSMA President-elect, Stanley Hartness, MD, left, and Peter F. Straley, center, speak with a forum participant after Mr. Straley's presentation.

ing River Medical Society's first program.

A review of Legislative issues were presented by Brent Alexander, Vice President, Government Relations and Public Information, MHA and Charmain Thompson, Director of Government Affairs, MSMA.

The evening concluded with a reception for Legislators and Forum participants. ❑



From left, Drs. Ed Hill, Myron Lockey, and Jim McIlwain.



Representative Carmen Wells-Smith



Representative Billy Broomfield



Enjoying the Reception from left are: Charmain Thompson, MSMA Director of Governmental Affairs, Nancy Lindstorm, Jo Waites, and Jimmy Waites, MD.

Review A Book

The following book has been received by the Journal MSMA. Members of the MSMA interested in reviewing this book should contact the Managing Editor, Journal MSMA. After submitting a review for publication, you may keep the book for your personal library.

Vandals at the Gates of Medicine — Historic Perspectives on the Battle over Health Care Reform. **Miguel A. Faria, Jr., M.D., Hacienda Publishing, Inc., Macon, Georgia, $41.95, 1995.**

About the author: Dr. Faria is Clinical Professor of Surgery (Neurosurgery) and Adjunct Professor of Medical History at Mercer University School of Medicine in Macon, Georgia. Dr. Faria has published over 60 articles ranging form scientific research papers on medicine and neurosurgery to essays on medical history and op-ed pieces on socio-economic and political issues affecting American society in general and health care in particular.

In addition to his responsibilities at Mercer, Dr. Faria is also the editor of the Journal of the Medical Association of Georgia and is active in health system reform at both the state and national levels. ❑

Diving Medicine in Grand Cayman, BWI

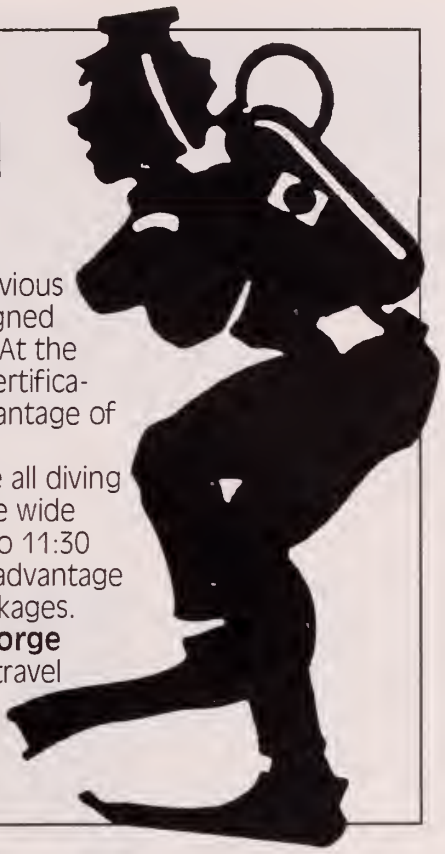
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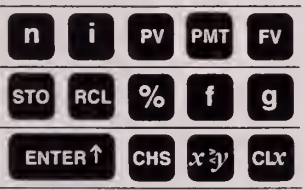
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MMPAC Wins Award

The Mississippi Medical Political Action Committee has been notified by the American Medical Political Action Committee (AMPAC) that MMPAC has won the first place membership award in the "all events" category for 1994.

This award is presented to the state PAC that finishes the highest in all of the following membership categories:

- Greatest percentage increase in membership,
- Greatest percentage increase in revenue,
- Greatest percentage of members to potential, and
- Highest percentage of sustainer members.

MMPAC also won the first place award in the category of "greatest percentage of members to potential". ❑

AMA Site Visit

Three representatives from the American Medical Association (AMA) visited the Medical Center on Jan. 25-26. They were Dr. Harry S. Jonas, AMA vice president for medical education and team leader, Dr. Yank D. Coble, Jr., of Jacksonville, Fla., an internist, and Michael Suk, a third-year medical student at the University of Illinois in Rockford.

The team conducted a discussion on the AMA for medical students, house staff and faculty at noon on Friday in R153.

The AMA established a medical school visitation program in 1986 to enhance dialogue between the academic medical community and the association. An important goal of the program is for the site team to serve as sounding board for the academic physicians and to obtain their suggestions as to how the AMA can become more effective in representing this group.

The AMA commits substantial resources to developing educational policy and to the accreditation of medical education programs at the undergraduate gradual and continuing education levels. Through visits of this kind, the AMA wishes to strengthen its ties with schools of medicine, explore issues of common concern and help those in the academic community better understand the Association and its extensive programs.

Dr. Jonas, a graduate of Washington University School of Medicine, St. Louis, Missouri, has been dean of the University of Missouri-Kansas City School of Medicine and chairman of the Department of Ob-gyn at that institution. In his present position with the AMA, he also serves as secretary of the Liaison Committee on Medical Education, the body responsible for accreditation of 126 US and 16 Canadian medical schools.

Dr. Coble was elected to the AMA Board of Trustees in June, 1994. He did undergraduate studies at Duke University and received his medical degree there in 1962. After completing his residency at New York Hospital Cornell Medical Center, Dr. Coble was an International Research Career Development Program awardee of the National Institutes of Health (NIH) at the Navy Medical Research Unit #3 (NAMRU) in Cairo, Egypt, at the NIH, and at Vanderbilt Medical School.

Dr. Coble currently serves on the AMA's Practice Parameters Partnership and the AMA Physicians Health Foundation Executive Committee. He is a clinical professor of medicine at the University of Florida, Jacksonville.

Michael Suk served on the AMA Council on Medical Service from 1992 until his election to the Board of Trustees in December, 1993. when he became the first medical student trustee to be directly elected by the Medical Student Section. Suk brings multiple perspectives to the Board of Trustees. In addition, to his medical degree, he is pursuing at once, a law degree at Boston University, as well as a master's degree in public health. ❑



AMA representatives visiting the Medical Center were from left: Yank D. Coble, MD; Michael Suk, and Harry S. Jonas, MD



Students and UMC Faculty were on hand to have lunch during a Q and A Session with the AMA Site Visit Team.



Dr. Coble, center, was pleased with his gift of Dr. Guyton's book presented by Dr. Conerly during the site visit as Dr. Mitchell and Dr. Turner looked on .



Pictured during the AMA Site Visit are from left, Dr. Harry Jonas, displaying his UMC sweatshirt, Dr. Yank Coble in back, Dr. Wallace Conerly; Dr. Don Mitchell and Dr. Helen Turner.

Cancer Clinic Presented Donation

The Children's Cancer Clinic was presented a $50,000 donation on Wednesday, Jan. 4, by Attorney General Mike Moore and Commissioner of Insurance George Dale in behalf of Metropolitan Life Insurance Company's support for cancer research throughout the country.

Accepting the check for the Medical Center were Dr. A. Wallace Conerly, vice chancellor for health affairs, and Dr. Jeanette Pullen, director of the children's cancer clinic and professor of pediatrics.

"Mississippi appreciates the generosity of MetLife and hopes that UMC will be the benefactor of other contribution from the insurance industry," Dale said.

"When our children are cared for, all Mississippians benefit," Moore said. "It is encouraging to see private enterprise contribute to the well being of our state.

According to Dale, this is the only donation of this type from any insurance company that has ever been made through his office specifically designated for research at the Medical Center.

More than 1,000 patients are treated at the cancer clinic each year for cancer, leukemia, sickle cell anemia and other blood disorders. These patients made about 7,000 visits to the clinic for treatment in 1994. ❑

Students Donate Food

MSHCA, the Minority Student Health Care Association at UMC, donated a month's worth of food to a needy family at Thanksgiving. The food drive was one of the organization's many community projects.

The organization traditionally sponsors a family at Thanksgiving. "This year MSHCA has had its most successful food drive," said James Bennett, MSHCA vice president and third-year dental student. "We were able to donate food not only for Thanksgiving, but for an entire month."

"This is Thanksgiving, a very special Thanksgiving," said Mary Lewis, recipient of the food. "It's been a very tough and long year for me and my family. You don't know what this means to me. You don't know how much I appreciate this."

"Donations were received from area churches, physicians, friends and family members of MSHCA members. We would like to thank everyone who assisted to make our project a success," Bennett said.

Established to promote health awareness and serve the community, MSHCA is composed of minority student from UMC's Schools of Medicine, Dentistry, Nursing and Health Related Professions.

"MSHCA members simply want to help the community and to show that there are African Americans in the health professional fields who are willing to contribute," said Michelle Gibson, MSHCA president and fourth year medical student.

Officers for 1994-95 are Michelle Gibson, president; James Bennett, vice president; Priscilla Green, treasurer, and Priscilla Sandifer, secretary.

In the upcoming months, MSHCA plans to sponsor a community health fair where citizens can receive blood pressure, cholesterol and dental screenings. Stress relaxation therapy also will be provided by physical therapy student. In addition, MSHCA members plan to visit Tougaloo College and Jackson State University to speak with undergraduate students interested in health professional careers. ❑



From left, Michelle Gibson, MSHCA president and fourth-year medical student, Marcus Reeves, second-year medical student. Jeanna Middleton, third-year medical student, Edward McGowan, support program coordinator in the Division of Minority Student Affairs, Dr. Leon Anderson, director of the Division of Minority Student Affairs, April Lee, first-year medical student and James Bennett, fourth-year dental student and MSHCA vice president.

Dr. Coney Ob-Gyn Department Head In Illinois

Dr. PonJola Coney, a 1978 graduate of the University of Mississippi Medical Center, has been named chair of the ob-gyn department at Southern Illinois University School of Medicine in Springfield. According to school officials, she is the first black woman in the country to receive such an appointment.

A McComb native, Dr. Coney earned the bachelor's degree in 1973 at Xavier University and came to UMC where she worked in the acute care laboratory until she decided to enroll in medical school. She completed her four-year residency in ob-gyn at the University of North Carolina at Chapel Hill in 1982 and a two-year fellowship in reproductive endocrinology and infertility at Pennsylvania Hospital in Philadelphia.

Dr. Coney is certified as a diplomate in ob-gyn by the American College of Obstetrics and gynecology and certified in reproductive endocrinology and infertility by the American Board of Obstetrics and Gynecology. ❑

Dr. McMullan Honored By AMA

Dr. Michael R. McMullan, resident in the Department of Medicine at the University of Mississippi Medical Center, was among 20 residents recently honored by the American Medical Association (AMA) for community leadership. Residents were selected for their involvement in community leadership and volunteer projects.

Dr. McMullan provides medical care at a volunteer clinic for indigent patients, has volunteered for the Special Olympics and hurricane relief, talked to local teens on the importance of education, and participates in the medical ministry at his church. ❑

20 Students Named To Who's Who

Twenty students from the School of Nursing at the University of Mississippi Medical Center will be included in the 1995 edition of Who's Who Among Students in American Universities and Colleges.

Campus nominating committees and editors of the annual directory have included the names of these students based on their academic achievement, service to the community, leadership in extracurricular activities and potential for continued success.

Students named this year are Rebecca Jeanette T. Adams, Rori E. Livingston Barnes, Christy Michele Callahan, Brenda Joy Castleberry, Johnnie Susan Cooper, Karen Elizabeth Edwards, Jennifer Sue Fortenberry, Nita G. Green, Kimberly Welch Hoover, Lynda Mechelle Kelly, Penny Michelle Koehne, Deborah McDaniel Macsherry, Jean Weeks McClaskey, Kimberly Ellis Moore, Harold Robinson Nichols, Mary Alison Pratt, Pamela Dennette Thrash, Lori Little Walker, Melissa Carol Wiley, and Parthenia Renee Williams.

These students join an elite group of students selected from more than 1,800 institutions of higher learning in all 50 states, the District of Columbia and several foreign nations.

Outstanding students have been honored in the annual directory since 1934. ❑

Dr. Martin Elected To CAOG Board

Dr. Jim Martin, professor of obgyn and director of the Division of Maternal-Fetal Medicine at the University of Mississippi Medical Center, was elected to the Central Association of Obstetricians and Gynecologists (CAOG) Board of Trustees, at a recent CAOG meeting in Memphis.

The CAOG covers the central part of the United States and has a membership of 1,001. ❑

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William Brawner of Tupelo announces the relocation of his office to the Tupelo Eye Center, 610 Brunson Drive, Tupelo.

Boyd P. Benefield and **Lynn E. Leatherwood** announce the formation of Orange Grove Medical Specialties, P.A. for the practice of Internal Medicine, 15441 Orange Grove Road, Gulfport.

Robert Brahan, an internal medicine physician at the Hattiesburg Clinic, was recently elected a Fellow of the American College of Physicians.

D. Timothy Cannon and **William C. Pinkston** have been named co-directors of Respiratory Therapy and the Sleep Disorders Center at Methodist Medical Center, Jackson.

C. Ralph Daniel, III, a Jackson Dermatologists, was recently a visiting professor at UAB discussing nail disorders.

Randy Easterling, a physician at the Street Clinic in Vicksburg, has been recertified as a Diplomate of the American Board of Family Practice.

David Hall of Natchez was recently appointed for a three year term to the Commission on Membership and Member Services of the American Academy of Family Physicians.

Richard L. Heyer, Jr., of Tupelo was recently appointed to serve as member of the board of directors of The Peoples Bank & Trust Company, Tupelo Associate.

Glyn R. Hilbun a general surgeon in Pascagoula has been named an associate director of the Pascagoula Sunburst Bank.

F. Lee Horn of Houston announces the relocation of his office for the practice of Family Medicine to the Family Medical Clinic of Vardaman, Highway 8 West, Vardaman.

Jack D. Lubensky has associated with the Gamble Brothers and Archer Clinic, P.A. for the practice of Urology, 344 Arnold Avenue, Greenville.

Earl L. Mahaffey of Jackson has been recertified a Diplomate of the American Board of Family Practice.

Alfred E. McNair, Jr. a gastroenterologist in Pascagoula has been named an associate director of the Pascagoula Sunburst Bank.

Don Q. Mitchell of Jackson has been re-elected treasurer of the American College of Allergy, Asthma and Immunology.

Rush Netterville a Mississippi Methodist Rehabilitation Center trustee and **Michael Winkelmann** of MMRC traveled to China recently to establish relationships

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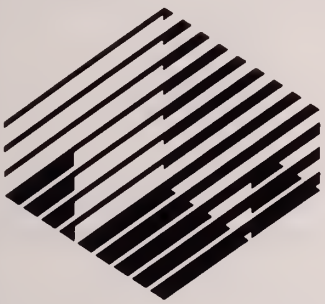
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with Chinese rehabilitation professionals. Visiting Hospitals in Beijing, Chengdn and Guangzhou, they found the Chinese using the latest technology. They also found that the Chinese mix traditional medicine with modern western medicine to form a unique approach to rehabilitation.

Eddie C. Starnes a gastroenterologists with Rush Medical Group, P.A. of Meridian was elected chief of staff during a recent meeting of the medical staff of Rush Foundation Hospital.

Glen L. Wegner of Clarksdale has been accredited by the American College of Radiology's Mammography Accreditation Program. ❑



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Physicians' Recognition Award



Three MSMA members were named recipients of the AMA Physicians Recognition Award in December. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

NORTHEAST MISSISSIPPI MEDICAL SOCIETY
Jessie Roma Taylor, MD

SOUTH MISSISSIPPI MEDICAL SOCIETY
John Richard Harper, MD
Peeler G. Lacey, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

Journal MSMA Placement and Classified ads are $2.00/line, with a 4-line minimum charge of $8.00. There are approximately 50-characters per line in 11 point Times Roman type; including each letter, space and all punctuation. Ad copy must be submitted in writing.

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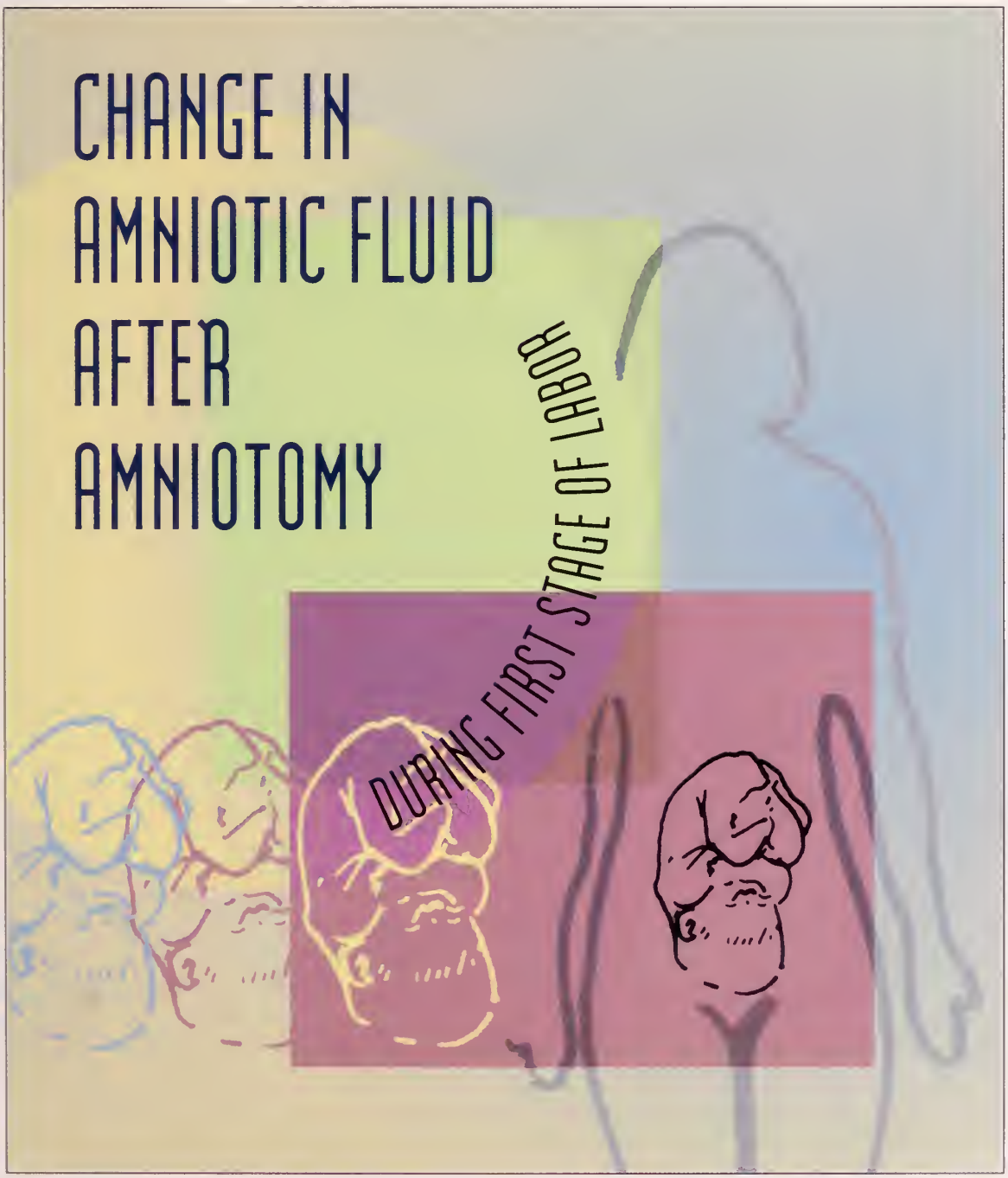
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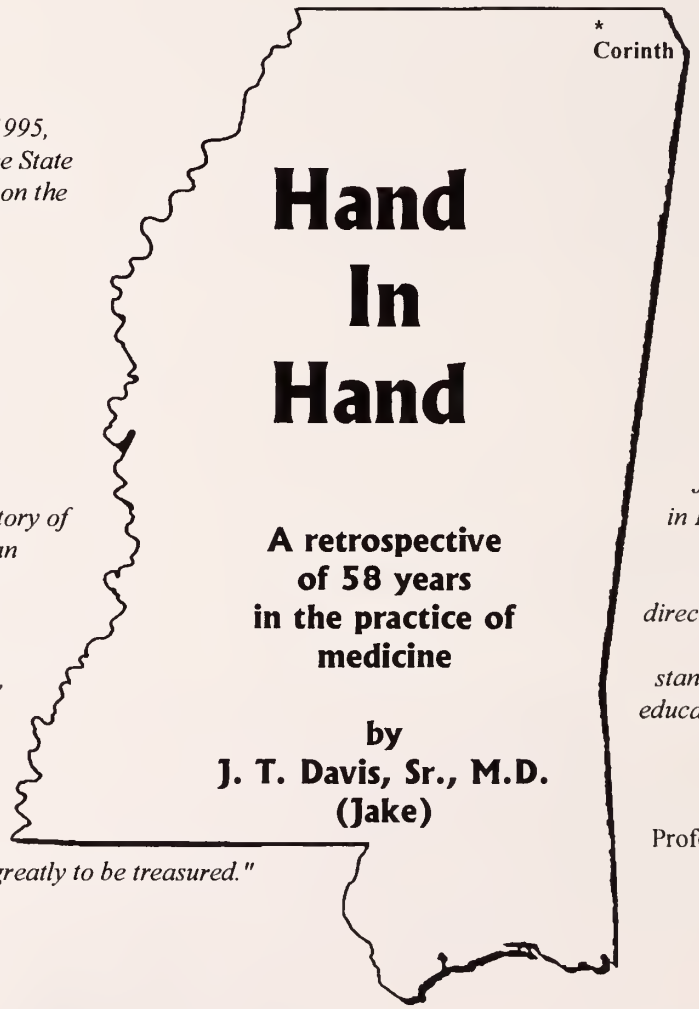


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written by Dr. J. T. (Jake) Davis, Sr. will be available to the public on May 15, 1995.

This book, about Dr. Davis' life will be his continuing contribution to medicine in Mississippi through the J. T. Davis, Sr., Foundation at the UMMC.

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— Alan E. Freeland, MD —
Professor of Orthopaedics, UMMC

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Memo

To: **President Clinton**
Members of the House and Senate

From: **The 300,000 member physicians of the American Medical Association**

Re: **Getting the job done on health care**

We believe there are several workable measures that can be passed now to help achieve our ultimate goal – making quality health care affordable and accessible to all Americans.

As the country awaits the State of the Union address, the member physicians of the American Medical Association set forth these practical recommendations to improve health care for our patients.

Insurance Reform – Pass insurance reforms that will make sure Americans will not lose their coverage if they change jobs or get sick.

Medicare Reform – Reform our Medicare system so it will be there for the next generation of elderly and disabled.

Medical Savings Accounts – Make MSAs available so people can pay for routine medical care with pre-tax dollars.

Patient Protections – Enhance patient choice, disclosure and assure greater physician involvement in corporate decisions about patient care.

Liability Reform – Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Regulatory Relief – Free both physicians and patients from the ever-increasing burden of needless and wasteful paperwork, regulations, obsolete anti-trust rules and red tape.

Medical Education and Research – Protect medical education and research so that we can find cures for killers like AIDS and cancer.

Public Health Problems – Fight social problems like violence and smoking — problems that cost billions of dollars and millions of lives.

These measures are sensible things we can do now that will make a difference for all of us. So, as we begin our nation's 104th Congress, we renew our pledge to the health of America. As the voice of the medical profession, we pledge to do everything we can to help make these things happen. It is <u>our</u> contract with America, and we fervently hope that every American will join us.

American Medical Association
Physicians dedicated to the health of America

Change In Amniotic Fluid Index After Amniotomy During First Stage of Labor

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The amniotic fluid index (AFI), a semiquantitative 4 quadrant technique to evaluate amniotic fluid volume, was originally described by Phelan et al[1] Volume assessment by this technique can be performed quickly, is easily taught, and is reproducible.[2] Using this technique, an AFI $\leq$ 5.0 cm is considered to be oligohydramnios. Rutherford et al[3] showed that a patient with intact membranes and an AFI $\leq$ 5.0 cm was at a significant risk for fetal heart decelerations, cesarean section for fetal distress, and low Apgar scores at 1 and 5 minutes. Sarno et al[4] has stressed the importance of a fetal admission test which includes initial fetal heart rate tracing or AFI in early labor. They demonstrated that even patients who present to the labor suite with spontaneous rupture of membranes and an AFI $\leq$ 5.0 cm in the latent phase of labor are at significant risk of an abnormal fetal heart rate tracing during labor, cesarean section for fetal distress, and an Apgar score < 7 at 1 minute. Decreased amniotic fluid volume by ultrasound in high-risk pregnancies, even if other parameters of the biophysical profile are reassuring, has been used as an indication for the induction of labor.[5]

Theoretically, all parturients with ruptured membranes (spontaneous or artificial) and continuous leaking of amniotic fluid are at risk of developing oligohydramnios and its associated complications. The purpose of this study was to determine 1) the incidence of patients with adequate amniotic fluid volume (AFI > 5.0 cm) on admission who develop oligohydramnios (AFI $\leq$ 5.0 cm) during labor, and 2) the relationship between the rate of decrease in the AFI and duration of ruptured membranes.

METHODS

This prospective study consisted of 41 women without any obstetric complications at a gestational age > 37 weeks admitted in labor over a 4-month period. All of these women had a fetal admission test which included a fetal heart rate tracing and an AFI. The AFI was determined as described originally by Phelan et al[1] using linear array real-time B-scan with electronic calipers. In this technique, the uterus was divided into four quadrants: by the umbilicus transversely (into upper and lower halves) and the linea nigra vertically (into right and left halves). The maximum vertical diameter of the largest pocket in each quad-

rant without an aggregate of cord or fetal extremities was measured in centimeters. A depth of 0 to 5 cm equates as oligohydramnios, 5.1 to 8 cm as low, 8.1 to 18 cm as normal, and above 18 cm as high. Both the initial and repeat measurement of the AFI were done by the same examiner to avoid interobserver variation.[2]

The study inclusion criteria were: 1) singleton pregnancies ≥ 37 weeks, 2) intact membranes, 3) cervical dilation < 4.0 cm, and 4) reassuring fetal heart tracing on admission. The exclusion criteria were: 1) multiple gestation, 2) spontaneous rupture of membranes prior to admission, and 3) intrapartum amnioinfusion. The duration of rupture of membranes was calculated from the time of amniotomy to the time of completion of the first stage of labor.

Statistical analysis was with Student t test or chi square test where appropriate. The sensitivity, specificity, and positive and negative predictive values of the linear regression equation to predict parturients who had adequate amniotic fluid prior to artificial rupture of membranes but have an AFI < 5.0 cm at the completion of the first stage of labor was calculated.

RESULTS

Eighty-two amniotic fluid indices were obtained on the 41 laboring patients at term. The initial AFI was performed on admission and then repeated when the laboring patient was completely dilated (10 cm). The mean (+ SD) AFI on admission was 10.6 ± 5.06 cm while the mean AFI at the completion of the first stage of labor was 8.4 ± 4.6 cm (p = 0.04). The mean duration of rupture of membranes was 5.47 ± 4.9 hours (range, 2.3 to 20.5 hours). All 41 parturients delivered vaginally with Apgar scores > 7 at 1 minute.

Table 1— The Amniotic Fluid Index (AFI) On Admission And At Completion Of The First Stage Of Labor

Admission AFI (cm)	n	AFI at the Completion of First Stage AFI ≤ 5.0 cm	AFI ≥ 5.0 cm
0-5.0	3	2	1
5.1-10.9	21	3	18
≥ 11.0	17	2	15

Table 1 summarizes the AFI on admission and at the completion of the first stage of labor. On admission, 3 patients had an AFI ≤ 5.0 cm, 21 patients had an AFI between 5.1 and 10.9 cm and 17 patients had an AFI ≥ 11.0 cm. One of the 3 patients with oligohydramnios on admission had normal fluid at the end of the first stage of labor. This patient had an admission AFI of 4.6 cm and after 13.2 hours of ruptured membranes had an AFI of 7.2 cm at the end of the first stage of labor.

The incidence of oligohydramnios (AFI ≤ 5.0 cm) was similar in the latent phase and at the completion of the first stage of labor (7.3% and 14.0%, respectively; p = 0.31). The duration of labor among the five patients who had an AFI > 5.0 on admission but had oligohydramnios at the end of the first stage of labor was not significantly different than the 34 patients who started and completed the first stage of labor with an AFI > 5.0 cm (5.0 ± 3.6 hours versus 4.5 ± 5.1; p = 0.85).

Patients with an admission AFI between 5.1 and 10 cm were as likely to have a low AFI at the end of first stage of labor (14.2%) as patients with an admission AFI ≥ 10.1 cm (11.7%; p = 0.80). The mean AFI decreases by 0.93 ± 2.67 cm/hour of ruptured membranes. Linear regression analysis reveals that after amniotomy, the change in AFI during first stage of labor can be described by:

Current AFI = Initial AFI - 1.0* (hours of ruptured membranes)

The sensitivity of this equation to identify patients who had adequate fluid prior to amniotomy but had oligohydramnios at the end of first stage of labor was 71.4%, while the specificity, and positive and negative predictive values were 55.9%, 25%, and 90.1%, respectively.

DISCUSSION

Amniotic fluid index, as described by Phelan et al[1] is clinically a very useful measurement of amniotic fluid volume. Oligohydramnios, defined as an AFI ≤ 5.0 cm, has an incidence of 8.5 to 15.5%.[3,4] Sarno et al[4] showed that, on admission, patients who presented with spontaneous rupture of membranes had a significantly higher incidence of oligohydramnios than patients with intact membranes (23.1 versus 8.8%, respectively). The morbidity associated with oligohydramnios, however, was similar among patients with intact membranes and an AFI < 5.0 cm and patients with ruptured membranes and an AFI ≤ 5.0 cm. Thus, intrapartum oligohydramnios, regardless of the membrane's

status, has morbidity. It seems plausible that after amniotomy, parturients with an AFI > 5.0 cm should eventually have an AFI ≤ 5.0 cm, and thus have risks associated with oligohydramnios.

There are four notable findings of this prospective study. First, both the mean AFI (10.6 ± 5.0 cm) and the incidence of oligohydramnios (7.3%) in this study are very similar to that reported by Rutherford et al[3] (10.5 ± 4.2 cm and 8.2%, respectively). Second, the mean AFI does change significantly after amniotomy during first stage of labor. Third, though 13% of the patients with adequate fluid on admission will have an amniotic fluid index ≤ 5.0 cm during the course of first stage labor, this is not a significant increase in the incidence of oligohydramnios. After amniotomy the decrease in mean amniotic fluid index and the increase in incidence of parturients with oligohydramnios is presumably due to continued leakage of fluid. Fourth, one patient with oligohydramnios on admission had an amniotic fluid index ≥ 5.0 cm at the end of first stage of labor. This paradox could be due to intraobserver variation or maternal hydration with fetal micturition. Further investigation with a larger sample size is required to confirm this finding.

In conclusion, after amniotomy, the amniotic fluid does decrease significantly during first stage of labor. In this study 13% of the parturients with adequate amniotic fluid prior to amniotomy had clinical oligohydramnios to onset of second stage of labor and this may explain the increase in "second stage variables decelerations" noted as labor progresses. ❑

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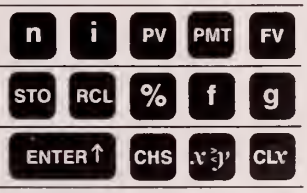
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Treatment Results In Laryngeal Carcinoma: A Study Of 109 Patients

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Vinod K. Anand, M.D., F.A.C.S.

Excluding skin tumors, squamous cell carcinoma of the larynx is the most common malignant tumor of the head and neck region. In the United States about 12,500 new cases and 3,800 deaths are predicted for 1994.[1]

Most recent surgical advances for treating patients with laryngeal carcinoma aim to conserve laryngeal function while extirpating the malignancy. In patients with advanced malignancy, however, the goal of functional preservation becomes increasingly difficult, if not impossible. Because many patients present with advanced laryngeal malignancies, we undertook an analysis of: (a) the extent of laryngeal tumors at the time of the patients' presentation to our institution, (b) the factors responsible for delaying the diagnosis of laryngeal carcinoma, and (c) survival rates in patients with laryngeal carcinoma.

METHODS

The medical records of 109 patients treated for laryngeal carcinoma at the University of Mississippi Medical Center over a period of 10 years (January 1, 1982, to December 31, 1991) were analyzed. Tumor locations were classified as supraglottic, glottic, subglottic and transglottic (Figure 1). The stage of disease in nonsurgical patients was based on the clinical and radiologic findings; in those treated surgically, the stage of disease was based on pathologic findings using the TNM staging classification. Treatment modalities and patient outcome were correlated to tumor staging and demographic and

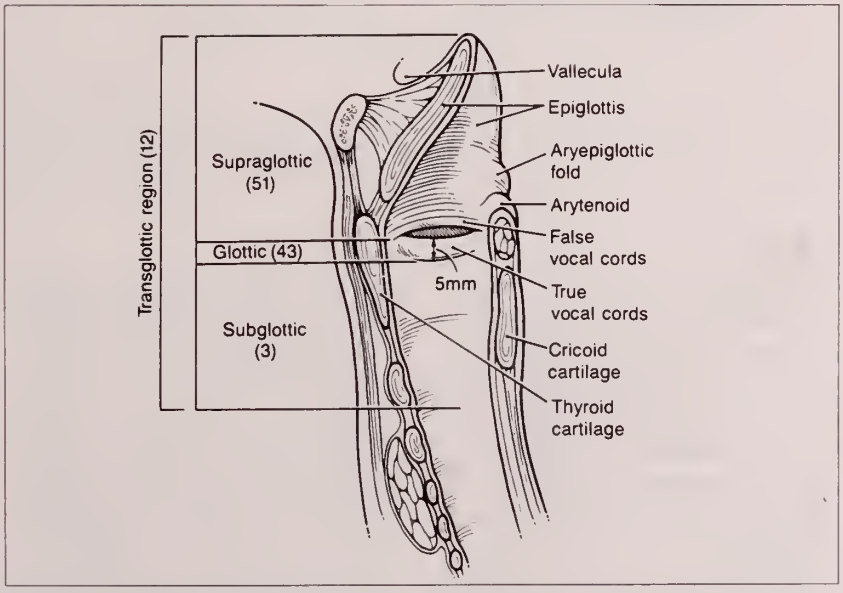


Figure 1: Sagittal section of the larynx illustrates classification and distribution of laryngeal carcinoma in our patients.

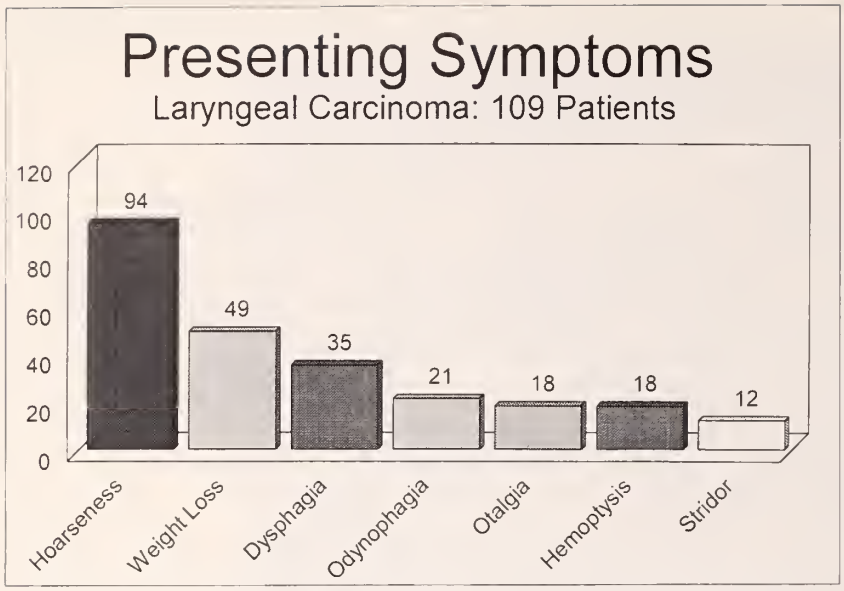


Figure 2: Presenting symptoms in 109 patients with laryngeal cancer.

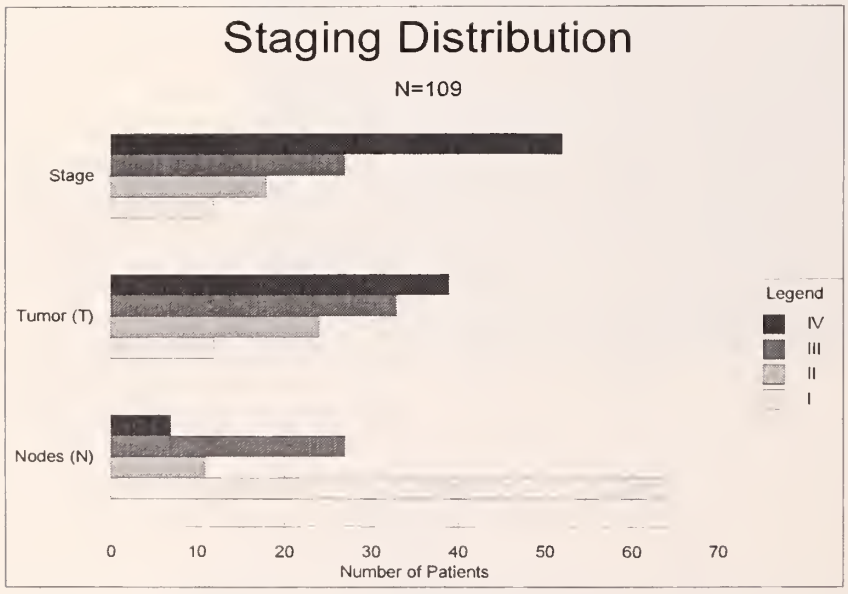


Figure 3: Staging and TNM classification in 109 patients with laryngeal carcinoma.

clinical data.

Empirical survival curves were constructed using the product-limit method[2] with comparisons based on the log rank statistic.[3] Multivariate survival analysis was conducted using the proportional hazards model.[4] A "p" value of less than 0.05 was considered significant. All analyses were performed using the SAS statistical package for personal computers (SAS Institute, Cary, NC).

RESULTS

Patient ages at the time of diagnosis ranged from 36 to 97 years (average 58.3 years ± 10.9 SD). Tumors occurred predominantly in men by a ratio of 3.5 to 1. Smoking and drinking alcohol were risk factors in 97% and 79% of patients, respectively. Hoarseness was the most common presenting symptom, appearing in 94 of 109 patients (86.2%), with a duration exceeding 1 month in 84 of 94 patients (89.3%). Figure 2 summarizes the clinical features of these patients.

Tumors appeared in the four sites as follows: supraglottic (51), glottic (43), transglottic (12) and subglottic (3). The TNM classification of tumors is shown in Figure 3. Two-thirds of the patients had large tumors (T3 and T4) at presentation, and 41% had clinically-evident nodal disease. The tumors in nearly three-quarters of patients (79/109) were stage III or IV. Three patients had metastatic disease at presentation.

Figure 4 summarizes the modalities used to treat these 109 patients. Fifty-one patients (46.8%) were treated using combined surgery and radiation therapy, 25 patients (22.9%) with surgery alone and 29 patients (26.7%) with radiation therapy alone. Of the 76 patients who underwent surgery, in only 18 were the tumors amenable to conservative laryngeal surgery. Thirty-nine patients died from their disease, two were alive with recurrent or persistent disease, and 68 were free of disease at the time of their last follow-up examination. Estimated overall median survival was 7.8 years, and the 5-year estimated proportion surviving was 56% (SD ± 6). A trend toward improved survivability, however, was evident in patients with glottic tumors (Figure 5). As expected, a comparison of survival based on TNM staging indicated poorer outcomes for patients with stage III or IV diseases. Subsequent analysis based on the individual T and N component markers (M was excluded because only 3 patients had metastatic disease) yielded no differences based on tumor aspect (T). There was, however, a significant impact on survival ($p < 0.0001$) when examined in the context of the nodal involvement (Figure 6). This dif-

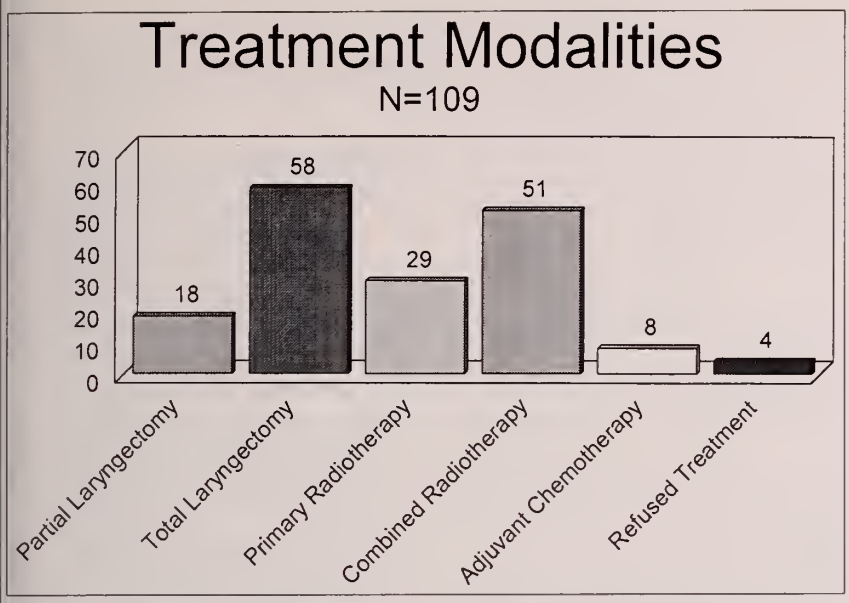


Figure 4: Treatment modalities in 109 patients with laryngeal carcinoma.

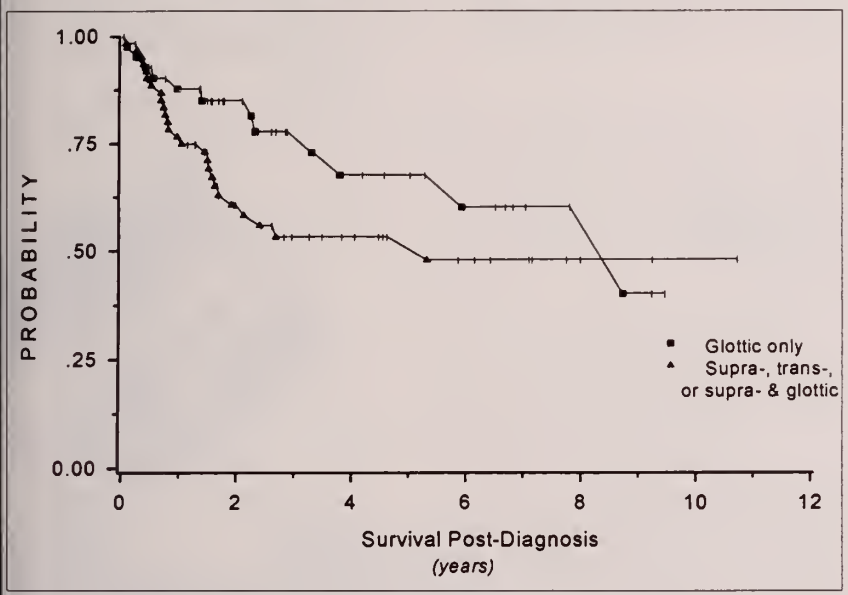


Figure 5: Comparison of survival in patients with glottic tumors versus tumors at other sites. There is a trend toward a better prognosis for those with glottic tumors ("p"=0. 1085).

ference existed between N0 and the combined N1, N2 and N3 categories, as no differences existed (p=0.1584) within this latter patient group with positive nodal status.

Multivariate analysis of survival was done to determine the existence of differential effects, if present, among cofactors. The variables considered concomitantly were age, primary site, and the individual T, N and M staging component markers. Both forward and backward implementing of the strategy of stepwise regression modeling selected nodal status (presence or absence of involvement) as the single factor significantly predicting survival outcome ($p < 0.0001$), mirroring the empirical result reported above.

Twenty-six of the 109 patients (23.8%) underwent a tracheostomy before any treatment for their laryngeal carcinoma. This subgroup of patients was analyzed and compared to the non-tracheostomy group with regard to stomal recurrence of the tumor, metastatic disease and survival. There was no significant difference among these subgroups in stomal or local recurrence (11.5% versus 19.2%, respectively), metastatic disease (7.6% versus 12%) or disease-free survival (50.0% versus 43.3%).

DISCUSSION

Laryngeal carcinoma predominantly affects men in their sixth decade of life. Over the past 30 years, the male to female ratio of laryngeal carcinoma has decreased from 11:1, as reported by Wynder[5] to 3.5:1 in our study.

The Heidelberg case control study of patients with laryngeal carcinoma showed a dose-response effect for tobacco and alcohol; there was a 9-fold increase in risk for both heavy smokers (>50 tobacco years) and heavy drinkers (> 75 g/day). The relative risks associated with tobacco and alcohol use are even higher for supraglottic tumors, with a 33-fold and 12-fold increase risk, respectively.[6] Our series included a higher proportion of supraglottic tumors (57.8 %) compared to those previously reported. This figure is twice the North American average[7] and similar to that reported in France, Italy and Hungary.[8] We attribute this higher incidence of supraglottic tumors to the combined effects of tobacco and alcohol consumption by our patients; nearly 80% consumed both heavily.

A myriad of host and tumor factors have been correlated with the prognosis of patients having laryngeal carcinoma. Host factors affecting prognosis include age,

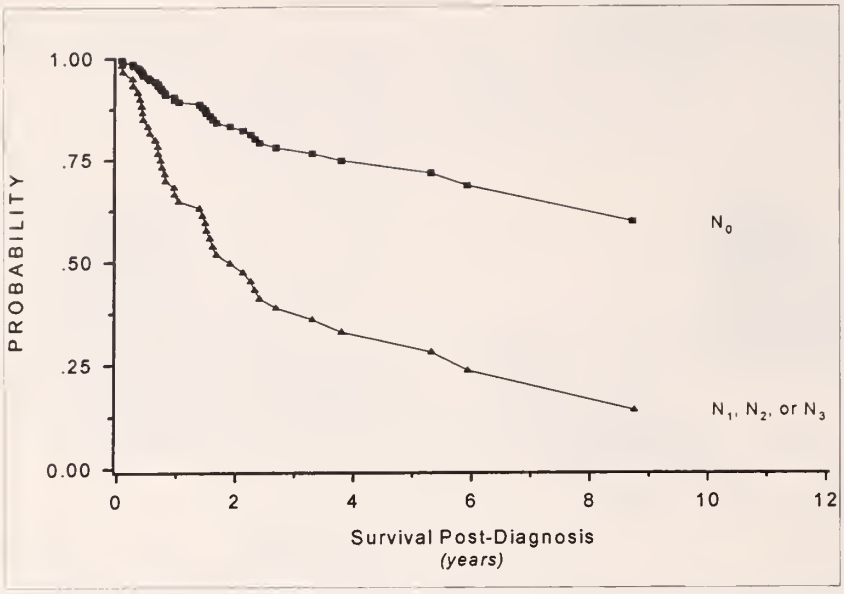


Figure 6: Survival rate in patients with laryngeal carcinoma as a function of nodal disease. The presence of nodal disease is associated with a worse prognosis ("p"<0.0001).

sex and performance status, which is the most significant.[9] Tumor factors predicting prognosis include: tumor extension, ulceration of the primary tumor, cord fixation, lymph node status, level of lymph node metastasis, histologic grading, pretreatment tracheostomy and treatment modality.[10,11,12] In our series, advanced stage (III and IV) and nodal disease correlated with a poorer outcome. There was a trend to better outcome in patients with primary glottic tumors. In multivariate analysis, only nodal status was a significant prognostic factor.

Surgery and radiation therapy are both highly effective as primary therapeutic modalities for early stages of laryngeal carcinoma. Local control rates of 98% and 93%, respectively, have been reported for T1 glottic carcinoma.[13,14] Advanced laryngeal carcinoma (stages III and IV) usually requires combined treatment including total laryngectomy[15,16] and offers cure rates of 35% - 45%. In selected patients, extended partial laryngectomy and near-total laryngectomy may allow the malignant tumor to be excised and vocal function to be preserved. For those patients needing a total laryngectomy, a tracheoesophageal puncture may provide adequate speech rehabilitation.

Seventy-two percent of the patients in our series had advanced disease (stages III and IV), and 41% had clinical evidence of nodal disease. Eighty-seven percent of our patients were from rural areas and half had no medical insurance. Ninety percent of the patients had symptoms for longer than one month, and 36% had symptoms for longer than 6 months. Although our 5-year survival rate of 56% and estimated overall median survival of 7.8 years compare favorably to those reported in the literature, the impact that a community cancer education program may have in improving early detection, survival and functional preservation of the larynx is obvious. We strongly recommend that any patient complaining of hoarseness or a sore throat lasting longer than 4 weeks, especially if he or she smokes or drinks alcohol, should be evaluated by an otolaryngologist.

CONCLUSIONS

1) Thirty-six percent of patients had symptoms of laryngeal carcinoma for longer than 6 months before presentation, and 90% for longer than one month. Early diagnosis and treatment is essential.
2) Seventy-two percent of patients in this series had advanced disease (stages III and IV).
3) Nodal disease adversely influenced prognosis in our patients.
4) A high proportion of supraglottic cancers was observed.
5) Five-year survival was 56%. ❑

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There Is An Alternative To Litigation

Harold (Hal) D. Miller, Jr.

You have a dispute over a transaction or perhaps you have been injured in an accident involving another party. What are your alternatives? The first alternative is to attempt to arrive at an amicable settlement of the dispute without involvement of the legal system.

Suppose, despite your best efforts and good intentions, an amicable solution is not forthcoming. What is your next alternative? Your next alternative is to utilize the legal system. Traditionally, and until recent years, the legal system offered a single alternative generally referred to as "litigation." Regardless of the subject matter, the complexity of the issues involved, the numbers of parties and the court in which the suit is pending, all litigation is the same in that it is time consuming, costly, emotional, and the parties have given the right to decide what the solution will be to a third party, be that third party a judge or a jury. Litigation is not designed to fashion solutions which are pleasing or satisfactory. It is designed to create a solution to problems the parties are unable to solve. This is done by following relatively narrow procedures.

Alternative dispute resolution ("ADR") offers alternatives to traditional litigation. The use of ADR techniques is growing throughout the United States. The Case Management Plan of the Mississippi Federal District Courts encourages the use of ADR. The Mississippi Bar has requested State court judges to encourage the use of ADR. There is a petition pending before the Mississippi Supreme Court seeking authorization of a pilot program of court annexed mediation in state courts. Mediation is being used in domestic cases in some chancery court districts.

There are two basic ADR methods, arbitration and mediation. They can be used with or without attorneys. It is not necessary that a lawsuit be pending for these procedures to be used. They are used in lieu of or as a supplement to litigation.

Arbitration has existed for years, however, until recently, its use has generally been in construction and labor disputes. Arbitration is a private, voluntary process where a neutral third party (arbitrator) hears witnesses, considers evidence, and renders a decision that is binding on the parties. The arbitrator is selected by the parties or appointed by a court or agency, and the proceeding is private. Arbitration provides a relatively quick, efficient and informal means of resolving disputes. The arbitrator sits as a judge and a finder of facts who has the authority to render a binding decision. This authority is based on the power granted to him by the parties, generally through a written contract. Generally, arbitration is more informal, faster, and less expensive than traditional litigation.

Mediation is of much more recent vintage. Although, like arbitration, a neutral third party (mediator) is used, the party serves a different function. In arbitration, the arbitrator's function is to make a binding decision for the parties, the same as a judge or jury. In mediation, the mediator, who

is generally trained in negotiation and mediation, assists the parties in arriving at their own, solution. The mediator does not make decisions. The mediator facilitates the parties in making their own decision. Because mediation is a negotiated solution satisfactory to all parties, it results in a "win-win" solution whose creativity is endless. Generally, it is substantially less time consuming and less expensive than traditional litigation and arbitration.

These alternatives are available to you. Some attorneys and organizations offer their services as arbitrators and mediators. Ask your attorney about the availability and feasibility of your use of these services or contact the MISSISSIPPI CENTER FOR DISPUTE RESOLUTION, an agency of the Mississippi Bar, at 1-800-747-2223.

*Mr. **Miller** is Chair, Alternate Dispute Resolution Group of Butler, Snow, O'Mara, Stevens & Cannada, PLLC, Jackson, Mississippi. Chair, ADR Committees of Mississippi Bar and Hinds County Bar Associations.*

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The President's Page

Mallan G. Morgan, MD

What's Happenin' ?

Do you know what's happenin' in:

Organized medicine in the AMA?
The MSMA?
Congress with regard to health care issues?
The Mississippi Legislature?
Managed health care in Mississippi?
Tort Reform?
Risk Management?
Liability Insurance?

If you don't know "what's happenin" in all of these areas and are wondering where you can get answers, buddy have I got a deal for you!

All of these issues and more will be addressed at the 127th Annual Meeting and Scientific Assembly of your Mississippi State Medical Association, May 17-21, 1995 at the Treasure Bay Resort Hotel, Biloxi, Mississippi. The managed care and liability issues listed above will be discussed in detail during the Friday morning Medicine Plenary and the Saturday morning Surgery Plenary Sessions.

Your MSMA House of Delegates will convene on Thursday morning to hear AMA President Dr. Robert McAfee address current issues in organized medicine. Reports and resolutions will be introduced at this initial meeting of the House for consideration by your references committees on Thursday afternoon.

Reference committees provide you an opportunity to voice your opinion and concerns. Did you know that the policies of your Association begin and are developed through issues presented at reference committees? If these committee meetings are not well attended, the voices of a few can speak for many. With the delivery of health care in such a state of flux, your Board of Trustees and Association staff need to know

(continued on page 76)

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVI, NUMBER 3
MARCH 1995

Laryngeal Carcinoma — A Relationship To Tobacco and Alcohol Use

In this issue of our Journal, Doctors Alemar and Anand present the treatment results in management of laryngeal carcinoma at the University Medical Center over a ten year period. Their study is consistent with prior reviews of laryngeal carcinoma, again demonstrating the relationship between this problem and tobacco and alcohol use. Ninety-seven percent used alcohol. This same relationship exist between other head and neck malignancies and tobacco and alcohol use. This is particularly true for oral cavity tumors where all forms of tobacco and alcohol use are strongly implicated as causative agents. While there has been a decrease in cigarette smoking in the general population there has been a concurrent increase in the use of smokeless tobacco. This is especially true for the younger patient population and as a result there has been an increase in tumor occurrence in this age group.

Another significant point addressed by Alemar and Anand is the marked shift in the male/female occurrence ratio for this tumor. Fifty years ago the ratio of male/female was approximately 50/I, thirty years ago that ratio was 11/I, and in this study a ratio of 3.5/1 was documented. This change parallels the progressive "liberation" of the female with a concurrent progressive use of tobacco. It is predicted that this ratio will become even in the next ten to fifteen years.

In general organized medicine has been very apathetic in confronting tobacco and alcohol as a public health problem in our population. While there has been a decrease in smoking in public facilities over the past few years there has been a steady increase in the use of smokeless tobacco.

How can we continue to be so inactive in addressing this issue. As physicians we need to become active participants in this struggle. A good place to start is with the school age group, especially the athletes, where there has been an explosion in the use of smokeless tobacco. Many of you perform physical examinations for school teams and that offers a great opportunity for you to get involved in this health issue. In talking with patients in this age group they universally state that they use smokeless tobacco because it is the "macho" thing to do. The real "macho" thing to do would be to say, "No, I am not interested and I do not consider it a necessary part of sporting activities".

(continued on page 76)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(President's Page continued from page 74)

what the membership wants to do. They can't know if you don't participate in the reference committee process. If you can not attend, please tell your delegate about your concerns. You may even want to write them down for him or her. If you can attend the reference committees during your Annual Meeting but are not willing to make the effort to participate in the process, don't complain about the policies that come from those who do.

In addition, if you attend the Annual Meeting and register your participation, you can receive category 1 CME hours toward the Physician's Recognition Award of the American Medical Association.

Of course, there are also the social activities which allow everyone the opportunity to see and visit with colleagues and friends. This year, the MSMA and MSMA Alliance Membership Party including the Alliance silent auction benefiting AMA-ERF will be held on Thursday evening. The MSMA President's Reception will be held on Saturday evening and there will be a lot of other special events in between.

I encourage you to make your reservation to attend the 127th Annual Session of your Association using the form packaged with this issue of the Journal or the reservation card you will be receiving with the MSMA Report. Remember, this is your opportunity to be heard.

It's going to be a great meeting, I hope you will choose to participate.



(Editorial continued from page 75)

As physicians the "macho" thing for us to do is get involved and fulfill our obligation to the public by at least trying to curb some of the use of tobacco and alcohol. Prevention and early diagnosis of head and neck tumors are a sure way to impact the future occurrence and management of these lesions.

Myron W. Lockey, MD
Editor

Letters

To the Membership of the
Mississippi State Medical Association:

Once again, we face an upheaval in medicine in the form of what has come to be called managed care. This potentially affects the University's mission in medical education, medical research and the mechanisms by which our University trains residents to ultimately join those of us in private practice who deliver the bulk of health care in this state.

The very real potential exists for University objectives to be in direct conflict and competition with the private physicians who frequently are loyal alumni and even Guardian Society members. I am hopeful constructive dialogue will continue which will allow us to reconcile this potential problem. The future and growth of the Guardian Society and thus its continuing support of UMC is dependent upon resolution of this issue.

Mart McMullan, MD
Guardian Society Chairman
Jackson, MS

THE GUARDIAN SOCIETY

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

As Guardian Society Chairman for the University of Mississippi Medical Center Alumni Association, I am pleased to recognize the hundreds of alumni and friends who have contributed over $7 million to the endowment fund for the School of Medicine. These members have provided funds for scholarships, loans, traveling fellowships, research, equipment, continuing education, lecturers, the Arthur Guyton Chair, and the James B. Hardy Chair. Faculty and students are benefiting from your generosity.

This commitment to our University can be traced back to 1972 when the Guardian Society was merely an idea of alumni. As fiscal belts were tightening by state and federal government and demand for medical education and services grew, these alumni established the Guardian Society to provide financial support to the University through private donations. It has become the premiere support group for the Medical School in helping maintain excellence in education.

The University of Mississippi Medical Center greatly values those alumni and friends who have given consistently over the years to attain membership in the Guardian Society. Thank you again for your generous support.



Mart McMullan, M.D.
Guardian Society Chairman
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Moving To Quality Improvement

Moving to Quality Improvement is the title of a special Foundation program scheduled for March 30 at the Lakeover Center in Jackson. Physicians and providers are invited to attend this event featuring a stimulating agenda highlighted with presenters from throughout our state as well as Texas.

They include:

- David Simpton, medical review officer with the HCFA regional office in Dallas;
- Dr. John O'Connell, chairman of the UMC Department of Medicine and consultant in the development of the Foundation's heart failure project; and
- Panelists representing several Mississippi hospitals. These presenters will be sharing quality improvement plans and candid feedback on recent experiences with the Foundation.

An update on current studies and projects underway with Mississippi hospitals will also be featured on the program.

The Foundation's Fourth Scope of Work with the Health Care Financing Administration has moved the peer review program into quality improvement projects designed to improve the quality of care for Medicare patients rather than the case-by-case review which was utilized for a number of years to measure quality.

We hope you as a Mississippi physician will become involved in this Health Care Quality Improvement Program which signifies a change in approach, a transformation for the Medicare quality review program in our state and throughout the country.

Please feel free to suggest possible projects for the future. Your interest and input at the March 30 program will be appreciated. Contact the Foundation office at 601-354-0304 for further information or to register for this workshop.

The AMA's 1995 Agenda – Legislative Priorities For Medicine

Medical Savings Accounts

Enacting Medical Savings Accounts (MSAs) into law will again be a prominent AMA legislative goal for the 104th Congress. In addition to supporting the more limited IRA-type medical expense account found in the "Contract with America," key House staff are developing a broader, more flexible MSA proposal. This proposal would allow individuals and families to pay for their medical expenses with pre-tax dollars while also maintaining coverage for catastrophic illness. Key House allies say this will be a top priority and are urging consideration within the first 100 days of the session. In the Senate, the AMA is working with Senator Judd Gregg (R-NH) who has said he will include an MSA as part of his health system reform proposal expected in the near future.

Regulatory Relief/CLIA

The AMA is pursuing a two-track strategy to achieve some relief for physicians from burdensome CLIA (the Clinical Laboratory Improvements Act of 1988) regulations. The AMA has long advocated the reform/repeal of CLIA. We are now joined in the effort by many who are now in the Republican majority in the House and Senate. In addition, we continue to work with the Clinton Administration to resolve the major difficulties stemming from CLIA and the 1988 CLIA Amendments. Other potential regulatory relief targets include OSHA blood borne disease requirements, Medicare "hassle" and physician ownership rules.

Professional Liability Reform

The House will soon consider H.R. 10, the Common Sense Legal Reforms Act of 1995. It is one of the planks in the House GOP "Contract with America." However, the Contract does not include relief for physicians from the constant threat of career-ending litigation spurred by unscrupulous trial lawyers. The AMA, along with many other groups working in coalition, will work to ensure that professional liability reform, including a cap on so-called "non-economic damages" is part of H.R. 10 when it is brought to the House floor. The vast majority of Americans support these reforms. Congress should support them as well.

Medicare

Expectations in Washington are that this year's Federal budget will include large cuts in Medicare, particularly physician payments. Whether these cuts are proposed to reduce the budget deficit, to finance a middle class tax cut or to fund incremental health system reform, the AMA will aggressively oppose them. Congress and the Administration cannot and should not once again favor short-term political expediency which will result

in long-term harm. Members of Congress and the Administration must understand that, ultimately, patients pay the price for such "quick fixes". Access to and quality of care will be affected. However, the AMA is eager to work with Congress to achieve a long-term stability in the program. Our recommendations include more equitable financing of the Medicare program; giving people who use Medicare a financial stake in their own health care decisions; opening up Medicare to price competition; tearing down Medicare's regulatory maze. Physicians as always are willing to contribute their fair share to controlling Medicare costs -- but the AMA will not stand for political expediency at the expense of our Physician members or our patients.

Patient Protection Act II

In 1994, elements of the AMA-drafted Patient Protection Act were included in every health system reform bill reported out of committee in both the House and Senate. Members of Congress realize that the time has come to provide protections for patients and physicians from the excesses of large managed care organizations. The Patient Protection Act II will have two important goals: Protections for patients through increased disclosure requirements and managed care fairness. Patients must have a right to choose their own physicians and their own health insurance plan; to know whether their doctor can be fired from a plan; to determine which procedures are covered and which are not; and to be informed as to what incentives providers receive for limited care. Physicians, on the other had, need to be able to ascertain the criteria for joining a plan and have defined rights and protections from arbitrary separation from the plan.

The Patient Protection Act II has been re-drafted based upon suggestions from Capitol Hill, from AMA members and the Federation of medicine. The new bill will be introduced soon.

Antitrust Relief

In the context of the consideration of broad-based health system reform, the AMA succeeded in winning some antitrust relief in various House and Senate committees last year. Since health system reform never made it to the Senate or House floor, that relief died with those comprehensive bills. This year, the AMA will launch a campaign to provide some antitrust relief for physicians wishing to compete in the new managed care marketplace.

Incremental Health System Reform

As mentioned above, incremental reform of the healthcare delivery system will likely be considered this session. The AMA will be working closely with Members of the House and Senate to advance reforms which will achieve intended goals, while at the same time limiting unintended consequences of incremental reform efforts.

The AMA pledge is to see to it that each of these initiatives is aggressively pursued in the 104th Congress. Please join us.

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National Practitioner Data Bank
Claims Reporting Changes

Effective December 1, 1994, the Department of Health and Human Services adopted new regulations regarding reporting requirements under the National Practitioner Data Bank. Following is a summary of some of those changes:

1. Individual practitioners are no longer required to report payments they make on their own behalf to the Data Bank. However, if the physician's insurer, professional corporation or any other business entity makes a settlement for the benefit of the physician, that payment must still be reported to the Data Bank. In order to be non-reportable, the settlement payment must be made out of the physician's personal funds.

2. Medical malpractice payments made solely on behalf of a corporation such as a clinic, group practice or hospital are not reportable to the Data Bank. A payment made on behalf of a professional corporation or other business entity that is comprised of a sole practitioner is reportable if the payment was made by the entity rather than by the sole practitioner out of personal funds.

3. In order for a particular physician or health care practitioner to be named in a medical malpractice payment report submitted to the Data Bank, the practitioner must be named in both the written complaint or claim demanding monetary payment for damages and the settlement release or final adjudication, if any.

4. If payment is made for several practitioners under one settlement or judgment, the medical malpractice payor must report the precise amount paid on behalf of each practitioner. If specific amounts cannot be determined for each practitioner, the payor must report for each practitioner the total amount of the payment and the total number of practitioners involved in the settlement.

5. A payment made to settle a claim is not reportable if the defendant is dismissed from the lawsuit prior to the settlement or judgment. However, if the dismissal results from a condition in the settlement or release, then the payment is reportable (meaning that if the practitioner is dismissed from the lawsuit in consideration of the payment being made in settlement of the lawsuit, the payment must be reported to the Data Bank).

For more information regarding changes in reporting payments to the Data Bank, see the upcoming issue of the MACM Monitor.

ACIERNO, MARIE D., Jackson. Born Bronx, New York, May 29, 1962; MD, State University of New York College of Medicine, Brooklyn, New York 1989; ophthalmology residency, New York Eye & Ear Infirmary, New York, 1990-93; neuro-ophthalmology fellowship, W. K. Kellogg Eye Center, Ann Arbor, MI, 1993-94; elected by Central Medical Society.

ARHELGER, ROGER B., Hattiesburg. Born Green Bay, WI, May 23, 1932; MD, University of Minnesota Medical School, Minneapolis, MN, 1958; pathology residency, University Medical Center, Jackson, MS, 1959-62; elected by South Mississippi Medical Society.

BOWLES, ALFRED P., JR., Jackson. Born Detroit, MI, August 30, 1957; MD, University of California School of Medicine, San Francisco, CA, 1983; general surgery residency, 1983-88; neurosurgery residency, Medical College of Georgia, Augusta, GA, 1988-93; fellowship, same, experimental neurooncology, 1987-88; experimental neurooncology, University of Washington, Seattle, WA 9/91-1/92;skull base surgery, University of Arkansas, Little Rock AR, 1993-94; elected by Central Medical Society.

BRYANT, GLEN EDWARD, JR., Amory. Born West Helena, AR, November 12, 1952; MD, University of Arkansas School of Medicine, Little Rock, AR, 1980; ophthalmology residency, University of Tennessee Center for Health Sciences, Memphis, TN, 1/90 - 12/81; elected by Northeast Mississippi Medical Society.

BURKS, SCOTT GERALD, Hattiesburg. Born Jacksonville, TX, March 10, 1964; MD, University of Texas Medical School, Houston, TX, 1991; pediatric residency, Vanderbilt Medical Center, Nashville, TN, 1991-94; elected by South Mississippi Medical Society.

COLEMAN, CHARLES CALVIN, Jackson. Born Mobile, AL, February 15, 1960; MD, Medical University of South Carolina College of Medicine, Charleston, SC 1986; psychiatry residency, Medical College of Georgia, Augusta, GA, 1956-89 1986-89; child & adolescent psychiatry fellowship, Vanderbilt Medical Center, Nashville, TN, 1989-91; elected by Central Medical Society.

CROW, JOHN ALLEN, Tupelo. Born Amory, MS, May 21, 1958; MD/PhD, Vanderbilt University School of Medicine, Nashville, TN, 1987; internal medicine residency, same, 1987-90; fellowship in Cardiology, Duke University, Durham, NC, 1990-94; elected by Northeast Mississippi Medical Society.

DABEZIES, EUGENE, JR, Jackson. Born New Orleans, LA, June 23, 1962; MD, Louisiana State University School of Medicine, New Orleans, LA, 1988; orthopedic residency, same 1989-93; fellowship in joint replacement & reconstruction, University of California at San Diego, San Diego, CA, 1993-94; elected by Central Medical Society.

FIELD, LARRY D., Jackson. Born Fort Smith, AR, April 17, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned one year and orthopedic surgery residency, University Medical Center, Jackson, MS, 1988-93; elected by Central Medical Society.



FLOYD, HERBERT BRUCE, Jackson. Born Tuscumbie, AL, August 9, 1950; MD, University of South Alabama School of Medicine, Mobile, AL, 1980; interned one year, Lloyd Noland Hospital, Fairfield, AL. Elected by South Medical Society.

FOROPOULOS, JOHN ERIC, Corinth. Born Memphis, TN, July 9, 1963; MD, University of Tennessee College of Medicine, Memphis, TN, 1989; interned one year, Methodist Hospital, Memphis, TN; orthopedic surgery residency, University of Tennessee Medical Center & Campbell Clinic, Memphis, TN, 1990-94; elected by Northeast Mississippi Medical Society.

FORTENBERRY, FRANK S., Tupelo. Born Memphis, TN, January 13, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine residency, Medical College of Wisconsin, Milwaukee, WI 1991-94; elected by Northeast Mississippi Medical Society.

GREENWALD, COREY STUART, Oxford. Born New York City, New York, April 27, 1963; MD, Brown University Division of Biological & Medical Sciences, Providence, RI, 1990; interned, Roosevelt Hospital, New York City, NY, one year; psychiatry residency, Mt. Sinai Medical Center, New York City, NY, 19991-94; elected by North Mississippi Medical Society.

GROSS, DEBORAH VIRGINIA, Gulfport. Born New Orleans, LA, March 5, 1954; MD, University of Texas Health Science Center, San Antonio, TX, 1983; psychiatry residency, University of Washington, Seattle, WA, 1983-87; elected by Coast Counties Medical Society.

HARLAN, WILLIAM ROBERT, III., Houston. Born Richmond, VA, May 10, 1963; MD, Duke University School of Medicine, Durham, NC, 1991; internal medicine residency, Same, 1991-94; elected by Northeast Mississippi Medical Society.

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LEWIS, RAYMOND, Meridian. Born Webster Co., MS, August 10, 1931; MD, University of Mississippi School of Medicine, Jackson, MS, 1957; interned one year, Baptist Hospital, New Orleans; dermatology residency, Northwestern University, Chicago, IL, 1958-61; elected by East Mississippi Medical Society.

MARTIN, MURPHY STUART, Jackson. Born Iowa City, IA, April 2, 1963; MD, University of Texas Southwestern Medical School, Dallas, TX, 1988; interned one year, Vanderbilt Medical Center, Nashville, TN; internal medicine residency, same, 1989-91; fellowship nephrology, same, 1991-94; elected by Central Medical Society.

PAREKH, KAMLESH H., Senatobia. Born Calcutta, India, June 20, 1955; MD, Medical College India, 1983; internal medicine residency, Henry Ford Hospital, Detroit, MI, 1987-90; elected by Northeast Mississippi Medical Society.

PARKER, DONALD R., Tupelo. Born Oxford, MS, May 1, 1957; MD, University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine residency, Same, 1991-94; elected by Northeast Mississippi Medical Society.

PITTS, TERRY C., Laurel. Born Laurel, MS, March 12, 1957; DO, Kirksville College of Osteopathic Medicine, Kirksville, MO, 1991; family medicine residency, University Medical Center, Jackson, MS, 1991-94; elected by South Mississippi Medical Society.

PORTER, JOLIE G., Southaven. Born Baton Rouge, LA, January 11, 1964; MD, Louisiana State University School of Medicine, Shreveport, LA, 1990; internal medicine residency, Baptist Memorial Hospital, Memphis, TN, 1990-94; elected by Desoto County Medical Society.

RAVEL, RICHARD, Greenville. Born Clearwater, FL, August 9, 1932; MD, Columbia College of Physicians & Surgeons, New York City, NY, 1960; pathology residency, University of Miami Medical School, Miami, FL, 1961-65; elected by Delta Medical Society.

SAENZ, REBECCA B., Jackson. Born Vicksburg, MS, June 30, 1964; MD, University of Mississippi School of Medicine, Jackson, MS, 1990; interned one year, same; family medicine residency, University of Tennessee Medical Center, Memphis, TN, 1991-93; elected by Central Medical Society.

SAITTA, MICHAEL R., Tupelo. Born March 6, 1960; MD, John Hopkins University School of Medicine, Baltimore, MD, 1984; internal medicine residency, Same, 1984-87; rheumatology residency, Duke University Medical Center, Durham, NC, 1987-90; elected by Northeast Mississippi Medical Society.

SENTER, SUZANNE B., Jackson. Born New Orleans, LA, May 6, 1960; MD, Louisiana State University School of Medicine, New Orleans, LA, 1986; pediatric residency, University Medical Center, Jackson, MS, 1986-89; developmental & behavioral pediatric fellowship, same, 1992-93; elected by Central Medical Society.

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VASU, RENGA I., Southaven. Born India, March 12, 1949; MD, Madurai Medical College, Madurai, South India 1971; internal medicine residency, same, 1971-75; neurology residency, University of Tennessee Medical Center, Memphis, TN, 1982-85; elected by Desoto County Medical Society.

WILSON, RENEE G., Tupelo. Born Meridian, MS, May 3, 1964; MD, University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine residency, same, 1991-94; elected by Northeast Mississippi Medical Society.

WINSTEAD, WILLIAM BENEJAMIN, Gautier. Born Ellisville, MS, March 7, 1922; MD, University of Mississippi School of Medicine, Jackson, MS, 1958; one year internship, Greensboro, NC; elected by Singing River Medical Society.

WONG, ALEXANDER, Laurel. Born Hong Kong December 14, 1957; MD, University of Santo Tomas, Manila, Philippines, 1983; interned Booth Memorial Center, Flushing, New York, 1985-87; internal medicine residency, Chicago Medical Center, Chicago, IL, 1987-88; pathology residency, Booth Memorial Medical Center, Flushing, New York, 1988-90; medical oncology fellowship, Roswell Park Cancer Institute, Buffalo, NY, 1990-92; elected by South Mississippi Medical Society. ❑

Deaths

LINDSEY, ARTHUR W., JR., Cleveland. Born Cleveland, December 17, 1928; MD, University of Mississippi School of Medicine, Jackson, MS, 1958; interned one year, Arkansas Baptist Hospital, Little Rock, AK; Member of Delta Medical Society. Died January 24, 1995, age 65.



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Nutritional Support Of The Hospitalized Patient: A Team Approach

or

How St. Dominic Hospital saved its patients a half million dollars in TPN charges over two years

James S. Jones, MD
Bill Tidwell, PharmD
Judith Travis, RD
Teresa Spencer, RN
Paxton Phillips, CRTT, RCP
Bill Burford, RPh

Nutritional deficits have long been recognized as contributing factors to morbidity and mortality of hospitalized patients. A multi-disciplinary team approach to nutritional support has been shown to be superior to non-team approaches. A formal consultive nutritional support team has been active at St. Dominic Hospital since 1991. The benefits of our nutritional support team at St. Dominic Hospital are described. Acquisition of an Indirect calorimeter has improved measurements of caloric and substrate requirements. Individualized nutritional prescriptions more closely meet assessed patient needs. Utilization of less expensive, more physiologic enteral feeding routes have increased. Also, the number of total parenteral nutrition (TPN) bags admixed and wasted have decreased, despite an increase in the percent of patients with moderate to severe nutritional risk. The nutritional support service at St. Dominic Hospital has improved patient care while reducing cost to both the institutional and patient.

The provision of individualized support has become increasingly more complex and requires understanding of nutrition, biochemistry, anatomy, pathology, physiology, pharmacology and epidemiology. To maximize benefits and minimize complications, it has been recommended that a team approach be taken in delivering individualized nutritional support. The American Society of Parenteral and Enteral Nutrition has published standards of practice and also guidelines for the use of parenteral and enteral nutrition in adult and pediatric patients.[1]

The importance of a nutritional support service has been documented in multiple studies comparing the incidence of complications when a team approach is taken and when it is not. In

1980, Nehme compared catheter and metabolic complications in two hospitals, one with a nutrition support service and one without. He found the presence of a nutrition support team reduced catheter insertion complications from 33% to 3.2% and decreased catheter-related sepsis from 26.2% to 1.3%. A significant reduction was also noted in the incidence of metabolic complications.[2]

In 1984 Dalton demonstrated a considerable decrease in metabolic and technical complications when a consultative nutrition service was established in place of nutritional care given by individual primary physicians and even further reduction in complications when the nutrition team assumed complete control of total parenteral nutrition therapy.[3]

This experience has been confirmed by other authors, and based on these reports a team approach is now considered optimal for the delivery of total parenteral nutrition.

In January 1992, a multi-disciplinary nutritional support service was established at St. Dominic-Jackson Memorial Hospital. The team was led by a nutritional support service coordinator clinical dietician who coordinated the joint efforts of the nutritional support service (NSS). A medical director was appointed to act as medical advisor and an educational resource for the nutritional support service. The medical director oversees all aspects of direct patient care and assists in the development of the therapeutic goals for nutritional support. Additionally, a pharmacist is designated to round with the team and help individualize the nutritional support prescription for each pa-

TABLE 1. NUTRITION RISK ASSESSMENT

Level II Risk	Level III Risk
Inability to ingest food > 3 days Nutrient intake < 85% of estimated needs > 5 days; 75% - 80% of usual body weight & unintentional weight loss for last 6 month period; 70% - 79% of ideal body weight Serum albumin = 2.1 - 3.0 g/dl Total Lymphocyte count = 100 - 1500 cm^3 Diagnosis: GI problems, Obesity, Cardiac, Diabetes, COPD; Abnormal lab values associated with diagnosis.	≤ 75% of usual body weight & unintentional weight loss for last 6 month period; < 70% of ideal body weight; Serum Albumin < 2.1 g/dl Total lymphocyte count < 1000 cm3 Diagnosis: AIDS, Decubitis, Hepatic, Renal, Oncology, Enteral/Parenteral nutrition, Malnutrition; Treatments: Chemo/Radiation therapy, Acute or Chronic dialysis, Ventilator Support.

Evaluation Criteria:

Level II (Moderate) if:

- ≥ 2 of level II risk are positive; or
- ≥ 1 level II risk are positive + 1 level III risk is positive;

Level III (High) if:

- 1 level III risk positive = 3 level II risk are positive; or
- ≥ 2 level III risk are positive + > 1 level II risk are positive; or
- ≥ 5 level III risk are positive.

tient. As the team has grown, a nurse has been added who insures that intravenous sites and feeding tubes are appropriately maintained. More recently, a respiratory therapist has been assigned to the team for specific help with indirect calorimetry so as to further individualize the patient's nutrition support.

INCIDENCE OF NUTRITIONAL DEFICITS AT ST. DOMINIC-JACKSON MEMORIAL HOSPITAL.

Protein calorie malnutrition is associated with an increasing incidence of morbidity and mortality among hospitalized patients. In an effort to define a population at risk for the development of protein-calorie malnutrition, the dietary department at St. Dominic Hospital has, since 1991, carried out episodic nutrition screening studies and presently screens all patients admitted to St. Dominic for evidence of nutritional risk.

A screening is completed by a dietary technician and divides patients into the following three categories: Level I - no evidence of nutritional deficit.
Level II - moderate nutritional deficit.
Level III - significant nutritional deficit.

Clinical parameters used for identifying levels of nutritional risk are outlined in Table 1.

In 1991, a hospital-wide three month study was carried out in which 62% of 1040 admissions were found to have no evidence of nutritional risk, 33% demonstrated moderate nutritional deficits and 5% demonstrated significant nutritional deficits. In 1992, a selected study was carried out in the Critical Care Units over two months, screening 274 patients. The numbers were remarkably similar with 60% demonstrating no evidence of nutritional risk, 32% showing moderate nutritional deficit and 8% showing significant nutritional deficit.

A worrisome finding over the last two years has been the marked increase in the incidence of moderate and severe nutritional deficits that have been detected in the dietary screenings in Critical Care Units. In 1993, 1469 patients admitted to the Critical Care Units were screened and 28% of admissions showed no evidence of nutritional deficit while 64% showed at least moderate nutritional deficits and 8% showed significant nutritional deficits. Through the first 7 months of 1994, an additional 1059 admissions to the Critical Care Units had been reviewed and the incidence of moderate protein-calorie malnutrition had risen to 80%. Over three years the incidence of severe protein-calorie malnutrition has remained steady at 8-9% (Figure 1). At present, there is no obvious explanation for the rising number of patients who demonstrate moderate protein-calorie malnutrition on admission to the Intensive Care Units.

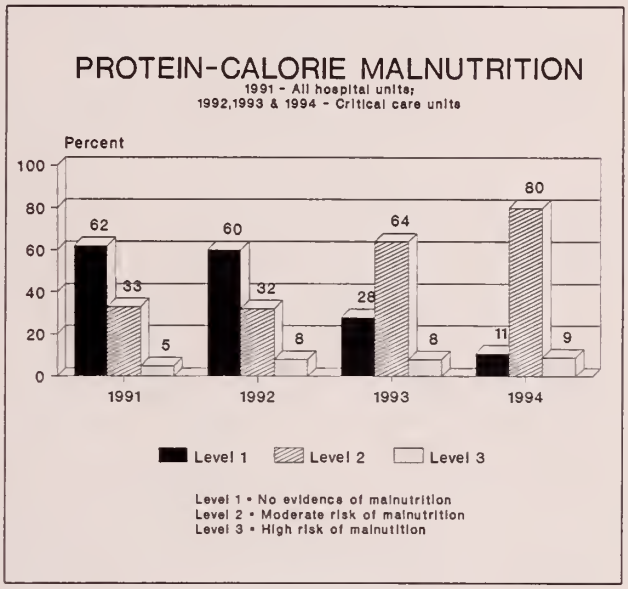


FIGURE 1

INDIVIDUALIZATION OF THE TOTAL PARENTERAL NUTRITION PRESCRIPTION

Nutritional support should be individualized to the patient's needs. The Harris-Benedict equation individualizes the nutritional prescription for each patient (see Table 2). Other formulas exist and suggests that critically ill patients be started at 25-30 kilocalories/kilogram/day. Guidelines also exist for the provision of individual feeding components. Most critically ill patients require 1.5 gram protein/kilogram/day in addition to 2.5-3.5 mg carbohydrate/kilogram/minute. The remainder of the calories are supplied in the form of lipids.

Experience Prior to 1992

Prior to 1991, total parenteral nutrition (TPN) was ordered via a standardized form which allowed the individual practitioner to choose between a standard solution of 8.5% amino acid or 5.5% amino acid mixed with a choice of 15%-25% dextrose. This generally led to the mixture of 1 liter bags containing 500 ml of 8.5% amino acids (with or without electrolyte additives), and 500 ml of dextrose 50% in water. At the physician's discretion, 200 ml of 10%

TABLE 2.
ENERGY REQUIREMENT ESTIMATION

HARRIS-BENEDICT EQUATION
(BEE = BASAL ENERGY EXPENDITURE)

BEE_{men} = 66.67 + 13.75W + 5.0H - 6.76A
BEE_{women} = 665.1 + 9.56W + 1.85H - 4.68A

W = weight in kilograms
H = height in centimeters
A = age in years

ACTIVITY AND INJURY FACTORS:

Activity Factors:	Injury Factors:
Confined to bed = 1.2	Surgery = 1.1 - 1.2
Out of bed = 1.3	Infection = 1.2 - 1.6
	Trauma = 1.35 - 1.6
	Burns = 1.5 - 1.9

TOTAL DAILY ENERGY REQUIREMENT (TDE)

TDE = BEE x activity factor x injury factor

or 20% lipid emulsion were given separately on an average of three times a week.

The nutritional support service undertook a study to determine the effectiveness of the above noted procedure to individualize a patient's nutritional prescription. Twenty random patients who had undergone nutritional support with total parenteral nutrition prior to 1991 were reviewed. Significant discrepancies were found and included an average variance in prescribed to delivered calories of 24.5%. Additionally, a variance in protein administration of 19.5% was noted, with individual variances as high as 92%. Carbohydrate administration differed from the ideal prescription on an average of 35.8%.

In 1992, following the introduction of a multidisciplinary nutritional support team with a goal of individualization of TPN prescriptions, the average discrepancy for calories, protein, and carbohydrates dropped noticeably (see Figure 2).

Reduction in Utilization

The team approach to nutritional support of critically ill patients at St. Dominic has been aided by the increasing use of enteral nutritional support. The

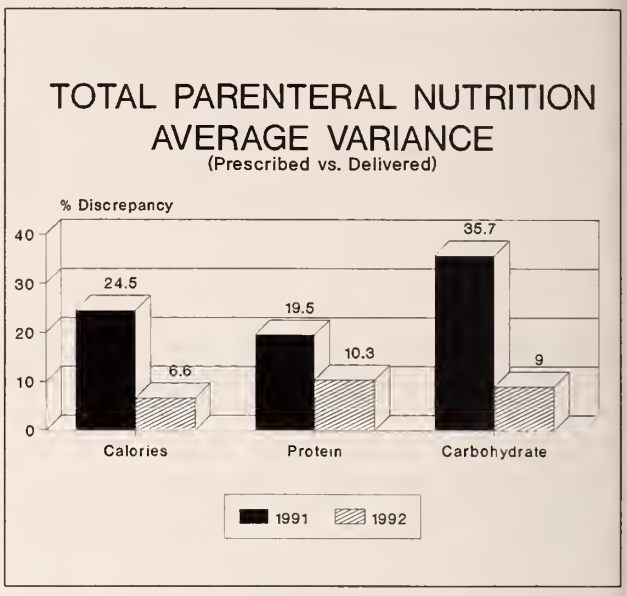


FIGURE 2

development of small bore enteral feeding tubes and the ability of the radiologists at St. Dominic to place these tubes beyond the pylorus (thus minimizing the development of gastric residual and reducing the possibility of reflux and aspiration) in critically ill and mechanically ventilated patients has led to earlier institution of intense enteral nutritional support. This has allowed the enteral feeding of many patients who formerly would have required a more expensive parenteral nutritional approach.

The parenteral nutritional formulary has also evolved since the conception of the team approach. Prior to the 3-in-1 admixtures, greater than 12 products of amino acids, carbohydrate (dextrose) and lipids were required to prepare the many different TPN formulations ordered. The utilization of 3-in-1 admixtures has allowed a reduction in the pharmacy inventory to primarily 3 products: 10% amino acid solution, 70% dextrose solution, and 20% lipid emulsion. Additionally, the use of a pharmaceutical compounder which mixes amino acids, carbohydrates and lipids into a single admixture that can hang for 24 hours has reduced the labor intensity required by both pharmacists and nurses. At present, patients at St. Dominic receive one total parenteral nutrition bag per 24 hours as compared to the more conventional three bags per day. In an effort to decrease the number of TPN bags prepared and wasted, the nutritional support team rounds daily at 9 a.m. All patients are reviewed and nutritional therapies are initiated or appropriate adjustments made. Subsequently, all TPN's are prepared in the afternoon, thereby incorporating any changes necessary for the next 24 hours. This has eliminated the need to change a TPN

Nutritional Support Assessment Summary

St. Dominic-Jackson Memorial Hospital
Jackson, Mississippi

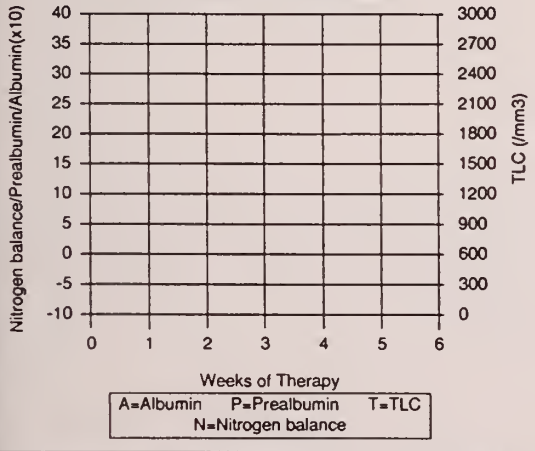
Diagnosis: _____

Hx: _____

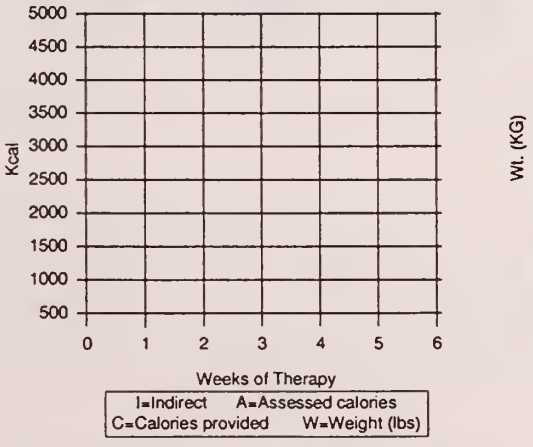
Ht: _____ Wt: _____ IBW: _____ IBW% _____ Caloric Needs: _____ Protein Needs _____

PARENTERAL (Start _____ End _____) Jutification: _____							ENTERAL (Start _____ End _____) Justification: _____						
Dextrose 70%							Formula						
mL							Strength						
g							Rate (mL/hr)						
mg/kg/min							Calories (kcal)						
calories							Protein (g)						
% cal from CHO							"Free water"						
Amino acids 10%							% USRDA met						
mL													
g													
calories													
% cal from AA							KCL (mEq)						
Lipids 20%							KPO_4 (mEq)						
mL							$Mg\ SO_4$ (mg)						
g							Ca gluconate (mEq)						
calories							MVI (mL)						
% cal from fat							Trace elements (mL)						
Total Calories							Reg. Insulin (units)						
Rate (mL/hr)							H_2 antagonist:						
Additional additives													

NUTRITIONAL ASSESSMENT



DIETARY PRESCRIPTION



Patient:	Room#	Physician	Hospital #	MR #

Rev. 9/94 SD 20-48

FIGURE 3

component after a bag has been admixed. To facilitate dissemination of the team's assessment and interventions, a nutritional assessment documentation form was developed and is placed in the medical record (Figure 3). Review of the data at St. Dominic has shown a significant decrease in the number of units of total parenteral nutrition prepared and the number of units wasted. In 1991 (prior to the development of a nutritional support service), 4558 units of TPN were prepared and over 5% of these were wasted. By 1993, with the use of early enteral feeding and 3-in-1 admixtures, the number of units prepared had fallen to 2389, a 48% reduction in units prepared (Figure 4). This has resulted in greater than $525,000 in patient cost-savings over two years. Additionally, total units wasted has fallen from 233 units in 1991 to 67 units in 1993, a 71% reduction (Figure 5).

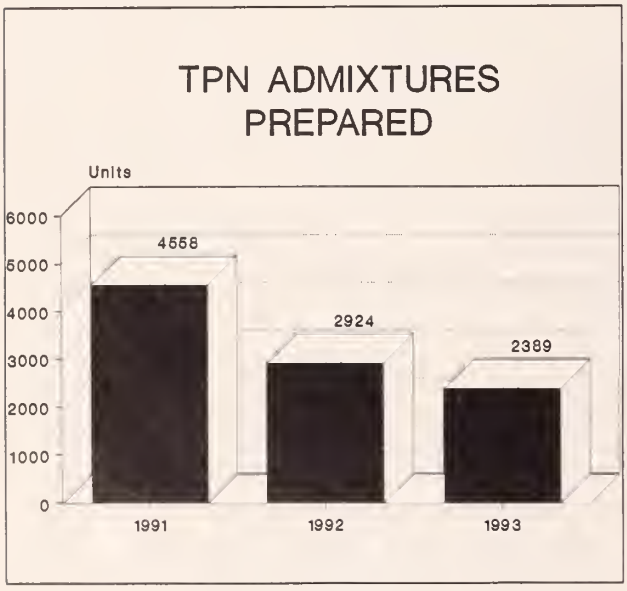


FIGURE 4

To further promote the use or early enteral feeding or 3-in-1 TPN admixtures, the nutrition support team recently developed an enteral order form and revised the parenteral order form. The forms encourage more individualized nutrition prescription as well as outline appropriate monitoring parameters (Figures 6&7).

FUTURE GOALS

In an effort to better individualize the nutritional support of patients at St. Dominic Hospital, an indirect calorimeter has been purchased for the calculation of energy expenditure through the precise measurement of respiratory gas exchange. Oxygen consumption or uptake and carbon dioxide production are measured and used to compute the patient's resting energy expenditure (REE). Although its development dates back over 200 years, indirect calorimetry's golden age was from 1930 to 1950 when it was used for the diagnosis and management of thyroid disease. More recently, its use has been directed toward the guidance of individualized nutritional support. The introduction of portable metabolic carts for bedside measurements has provided an accurate estimate of energy consumption so as to assess nutritional status and to determine the degree and need for nutritional support.

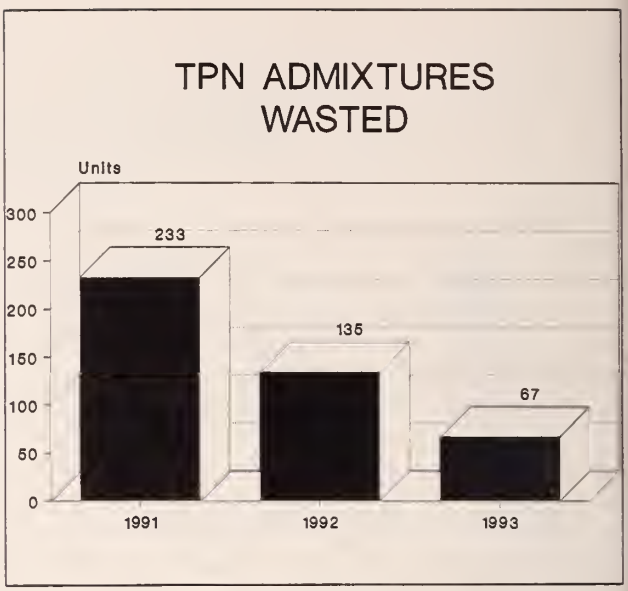


FIGURE 5

CONCLUSION

Protein-calorie malnutrition remains a common complicating condition for patients admitted to acute care hospitals throughout the country. In an era of declining hospital admissions, the incidence of protein calorie malnutrition among hospitalized patients has risen. In our experience, the incidence of moderate protein-calorie malnutrition detected on admission to the Intensive Care Unit has risen from 35% to 80% over a two year span. The development of a multidisciplinary nutritional support service has demonstrated improvement in the individualization of nutritional support for the hospitalized patient. Further improvement in applied nutritional support is evidenced by a 48% reduction in total number of units of TPN mixed since the institution of formal nutri-

ENTERAL NUTRITION ORDER FORM

ST. DOMINIC-JACKSON MEMORIAL HOSPITAL

☐ Consult Nutrition Support Service — RECOMMENDATIONS with ORDERS
☐ Consult Nutrition Support Service — RECOMMENDATIONS ONLY
✔ Dietitian will monitor changes if one of the above is not selected
Clinical Pharmacist, Ext #6640, Clinical Dietitian, Ext #6935, or Jimmy Jones, M.D.

PLEASE ☒ THE ITEMS YOU WISH TO ORDER

1. ☐ Place post-pyloric feeding tube (10f) in radiology. After positioned, use a magic marker to identify proper placement at exit site. Please do this prior to sending back to floor.



X marks tube placement

Radiologist:
Tube marked at nostril: ☐ by:
Date:
Time:

☐ Insert enteral feeding tube (10f), obtain a portable KUB. After position is confirmed, use a magic marker to identify proper placement at exit site.
☐ Use PEG tube for feedings.
☐ Other

2. ☐ 1.0 cal/mL lactose free ☐ 1.0 cal/mL fiber containing ☐ renal (pre-dialysis)
☐ 1.5 cal/mL lactose free ☐ 1.0 cal/mL elemental ☐ renal (during dialysis)
☐ 2.0 cal/mL lactose free ☐ diabetic formula ☐ pulmonary formula
☐ Other

3. ☐ Bolus Feedings _____ mL q hrs. Check residuals before each bolus feeding. If > _____ cc's, then hold.
☐ Begin formula at full strength _____ mL/hr and increase rate q_____hrs by _____ mL until rate of_____ mL is obtained. DO NOT increase rate if patient is experiencing diarrhea, nausea, or vomiting and please inform Nutritional Support Service at Ext #6935.

4. ☒ Add blue food coloring to enteral feeding. (2cc food coloring per can of formula)
5. ☒ Clean site around tube daily with mild soap and water. Notify physician of exudate or redness.
6. ☒ HOB is to be elevated 30° when feedings in progress.
7. ☒ Irrigate feeding tube with 30cc of H_20 q 4 hrs. Flush with H_20 before and after giving medications.
8. ☒ Check residuals each shift and document. Reinsert contents back into stomach unless > 150cc.
9. ☒ Hang only 4 hrs worth of formula in each bag.

MONITORING ORDERS

1. ☐ Weigh patient daily and record
2. ☐ Fluid intake and output (I & Os) q shift with 24 hr totals
3. ☐ Pre-albumin: ☐ Today ☐ Every Sunday and Wednesday
4. ☐ 24 hr urine collection for UUN (nitrogen balance) after goal rate obtained
5. ☐ SMA-12 ☐ Today ☐ Weekly

ADDITIONAL INSTRUCTIONS

Date: / Time:	Signature:

Patient Name	Room #	Physician	Hosp. #	MR #

9/94 SD 20-63

FIGURE 6

PARENTERAL NUTRITION ORDER FORM

ST. DOMINIC-JACKSON MEMORIAL HOSPITAL

☐Consult Nutrition Support Service - RECOMMENDATIONS with ORDERS.
☐Consult Nutrition Support Service - RECOMMENDATIONS ONLY.

Notify the following persons:
Clinical Pharmacist, Ext.# 6640, Clinical Dietitian, Ext.# 6935, or the Nutrition Support Service Medical Director
• Dietitian will monitor if one of the above is not selected.

THREE IN ONE (3:1) PARENTERAL NUTRITION FORMULATION

(ALL TPN BAGS ARE 24 HOUR INFUSIONS]

Amino Acids 10%	_____ mL	[_____	g/	_____ Kcal]
Dextrose 70%	_____ mL	[_____	g/	_____ Kcal]
Lipids 20%	_____ mL	[_____	g/	_____ Kcal]

Calcium gluconate	_____ mEq	Potassium acetate	_____ mEq
Magnesium sulfate	_____ mEq	Sodium acetate	_____ mEq
Potassium chloride	_____ mEq	Sodium chloride	_____ mEq
Potassium phosphate	_____ mEq	Sodium phosphate	_____ mEq
MVI-12	_____ mL	Folate (Folic acid)	_____ mg
Trace elements	_____ mL	Ascorbic acid	_____ mg
H_2 Antagonist:_____	_____ mg	Zinc sulfate	_____ mg
Regular Human Insulin	_____ units		

Infuse thru a 1.2 micron filter @ _____ mL/hr

MONITORING ORDERS

(CHECK AND COMPLETE ALL THAT APPLY)

☒ Fluid intake and output (I/O's) q shift with 24 hour totals.
☐ Weigh patient daily.
Electrolytes and magnesium: ☐ TODAY; ☐ every day x 3, begin tomorrow AM.
SMA-12: ☐ TODAY; ☐ tomorrow AM, and every Monday and Thursday AM.
Pre-albumin: ☐ TODAY; ☐ every Wednesday.
☐ 24 hour urine for urine urea nitrogen, begin urine collection: _____
☐ Metabolic Study: _____
☐ Capillary glucose every _____ hours.
☐ Sliding scale regular human insulin as follows:

Glucose (mg%)	Dose units
≤ 200	0 SQ
201-250	5 SQ
251-300	8 SQ
301-350	12 SQ
351-400	16 SQ
≥ 401	20 SQ , recheck glucose in 2 hours.

☐ If glucose < 60 mg% administer 25mL Dextrose 50% IV, and inject 25mL Dextrose 50% into remainder of TPN - notify nutrition team or prescribing physician ASAP.
☒ TPN infusion rate may be decreased as necessary to make bag (TPN) last until next bag available (~ 1600 hrs).
☒ If TPN bag is completed early, hang Dextrose 10% and infuse at 50mL/hr until next TPN bag available

Prescriber Signature:

Thank You,

Patient	Room #	Doctor	Hospital #	MR #

Rev: 9/94 SD 44-42

FIGURE 7

tional support service and a cost savings to patients of $525,000 over two years. Additionally, waste of TPN bags has been reduced greater than 70% with the initiation of a nutritional support service. Through a team approach to nutritional support, we have improved patient care while decreasing both patient and hospital expenses at St. Dominic-Jackson Memorial Hospital.

The authors wish to thank Sonny Jones, R. Ph., Janet Scruggs, R.D. and Gayla Bridges for their valuable assistance. ❑

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Jackson, MS 39216

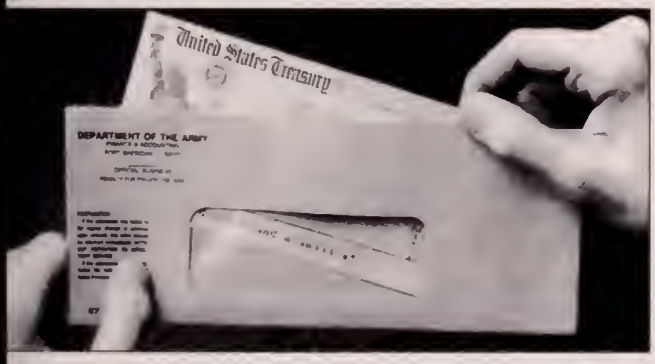
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CASE RECORDS
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CLINICOPATHOLOGIC CONFERENCE IX

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Simon F. Shakar, MD

Joe C. Files, MD, *Editor*

Differential Diagnosis: **Russell S. Tarver, MD**
Radiological Findings: **Gregory N. Vickers, MD**
Pathological Findings: **Bret C. Allen, MD**

CASE PRESENTATION

A 27 year old black male was referred to the University Medical Center for evaluation of anemia. He was in his usual state of excellent health until August, 1992, when he first noted development of dizziness and light headedness with standing as well as a loss of appetite. These symptoms continued and he sought medical attention from the referring physician in September, 1992. Workup at that time found him to be anemic with a diagnosis by Hgb electrophoresis of â thalassemia. He was followed by the local physician and documented to have continued weight loss over the next five months of 24 lbs.

Further workup at the outside institution included a chest x-ray reported as abnormal with hilar adenopathy and a CT of the abdomen which was reported as normal. Other labs available included a ferritin of 171, testosterone of <10, and a prolactin of 14.9. He was then referred to UMC for workup.

Further history obtained here included continued anorexia and weight loss with no dysphagia, nausea, abdominal pain, or change in bowel habits. He did have a past history of peptic ulcer disease treated approximately 4 years prior to admission with resolution of symptoms. He complained of mild shortness of breath with exertion but denied significant cough, sputum, or hemoptysis. He had no complaints of fever or night sweats. Other symptoms elicited included recent difficulties with ejaculation and decreased libido; however, he denied impotence. He also related a history of GC urethritis treated approximately 5 years prior to admission, but he denied any other risk factors for HIV. He has a 3-4 pack year history of smoking but denied any significant alcohol or IV drug abuse.

On physical examination, his vital signs revealed a temp of 98, supine blood pressure of 100/60 with pulse of 72, and a palpable blood pressure of 80 with a pulse of 104 upon standing. He was 6'0" and weighed 144 lbs. His exam was normal with the exception of a 2cm firm and nontender right epitrochlear lymph node, multiple hyperpigmented scars over his trunk and extremities, and a small thrombosed hemorrhoid with brown heme + stool.

Admission laboratory included a platelets count of 321,000, a white cell count of 4800, and a hematocrit 35.5% with an MCV 65.7 fl. His differential included segs 43%, bands 2%, lymphs 30%, monos 11%, eosinophils 12%, basophils 2%, retic 2.0%.

Other lab values included: Na 134 mmol/l, K 3.9 mmol/l, Cl 98 mmol/l, CO2 29 mmol/l, BUN 11 mg/dl, creatinine 1.0 mg/dl, glucose 112 mg/dl, calcium 8.3 mg/dl, albumin 3.6 g/dl, total bilirubin 1.3 mg/dl, GGT 20 u/l, ALT 25 u/l, AST 47 u/l, urinalysis with trace proteinuria, sp gravity 1.025, and pH 6.0. He had a T4 of 4.5 µg/dl, a T3RU of 32u, a TSH of 1.62 µIU/ml, a testosterone of < 20.0 ng/dl, and an early a.m. cortisol of 2.5 µg/dl.

A chest x-ray confirmed bilateral hilar and mediastinal adenopathy with left apical pleural thickening (Figure 1). Hemoglobin electrophoresis reported an A2 of 8.4, FID was negative, and RPR was NR.

A diagnostic procedure was then performed.

Dr. Tarver: This young man had a six month history of postural hypotension associated with anorexia and subsequent loss of libido. He had mild dyspnea on exertion. There was a past history of peptic ulcer disease and of a sexually transmitted disease. He had one palpable peripheral lymph node described and hyperpigmentation of old scars was noted. Stool was hemoccult positive. Chest x-ray revealed mediastinal and bilateral hilar adenopathy. He was mildly anemic. Hemoglobin electrophoresis demonstrated beta-thalassemia. Hormonal assays revealed a number of abnormalities.

Chronic orthostasis is generally due to autonomic dysfunction or chronic intravascular volume contraction. The record reveals no other evidence of neurologic disease and the patient is on no medications



***Figure 1**: Bilateral hilar and mediastinal adenopathy with left apical pleural thickening.*

that would interfere with autonomic reflexes. There are no historical factors to suggest excessive gastrointestinal, dermal or renal losses of electrolytes and water. Anemia is not a cause of orthostasis although some causes of anemia can be associated with orthostasis. Beta-thalassemia is not such a cause and is irrelevant to this patient's course. He has a history of peptic ulcer disease and his stool is hemoccult positive. Although acute gastrointestinal bleeding can cause acute orthostasis, it would not account for chronic orthostasis. The trace of blood in his stool needs further attention but is unlikely to be related to his main symptoms. The above mentioned hormonal abnormalities, however, offer a ready explanation of the patient's orthostasis as well as of his anorexia, weight loss and loss of libido.

Testosterone and cortisol are unequivocally low. His free T4 index is slightly low in view of a low normal T4 and a low T3RU. He has either multiple endocrine end organ failure or panhypopituitarism. If he had primary adrenal failure, he would have lost mineralocorticoid production with consequent hyperkalemia; the fact that his potassium is normal suggests that he is still producing aldosterone, as he would with adrenocorticotropic hormone (ACTH) deficiency from panhypopituitarism. Similarly, if he had primary thyroid failure, his thyroid-stimulating hormone (TSH) should be significantly elevated; instead the TSH is low normal. In pituitary insufficiency the TSH may be low, normal or even slightly elevated due to the production of an immunologically reactive TSH that is not fully functional due to failure of TSH glycosylation by the improperly functioning pituitary. I interpret the data to reflect panhypopituitarism due to either failure of the pituitary itself or due to lack of releasing factors from the hypothalamus.

The above interpretation should be confirmed by assaying ACTH, luteinizing hormone (LH) and follicle stimulating hormone (FSH). If my supposition is correct, these levels will be low. I will proceed on the basis that they were indeed low.

Assignment of the anatomic abnormality to either the hypothalamus or the pituitary can be accomplished by hypothalamic releasing factor stimulation testing. For instance, administration of thyroid releasing factor (TRF) can be followed by TSH measurements. A damaged pituitary gland will not respond to TRF whereas a pituitary gland lacking in stimulation from a damaged hypothalamus will respond to TRF with increased output of TSH. Similar testing can be done by serial administration of gonadotropin releasing hormone followed by assays of FSH and LH. When available, corticotropin releasing factor (CRF) can be given and ACTH response subsequently measured. In the absence of commercially available CRF, ACTH production can be stimulated by inducing hypoglycemia with insulin.

Once his adrenal and thyroidal deficiency states are corrected, it would be interesting to assess his ability to conserve and excrete water. Osmotic control by antidiuretic hormone and by thirst is frequently disrupted with disease in this area of the brain.

The patient's primary symptoms are readily explained by his panhypopituitarism but what is the likely etiology of his panhypopituitarism? Fortunately, we have another finding to suggest possible etiologies; the patient has mild dyspnea in the presence of mediastinal and bilateral hilar adenopathy.

Sarcoidosis is by far the most likely cause for this man's chest x-ray pattern; the findings are typical for that disease. Sarcoidosis is well recognized as a cause for both pituitary and hypothalamic disease. The hyperpigmentation changes that described this patient's old scars are also typical of sarcoidosis

but are not noted in the other diseases discussed below. It would be helpful if eye examination findings had been described since central nervous system involvement by sarcoidosis is very often accompanied by the chronic uveitis of sarcoidosis.

Neurologic involvement occurs in about 5% of patients with sarcoidosis. The most common presentation of neurosarcoidosis is cranial neuropathy, typically seventh nerve palsy, often with bilateral involvement. Next in frequency of involvement is the eighth cranial nerve with either auditory or vestibular function or both being impaired. All other cranial nerves have at times been affected but at a much lower level of frequency. Aseptic meningitis occurs in approximately 1% of sarcoid patients and can present with either hormonal problems as in this patient or with disruption of appetite, thirst, or temperature regulation. About 0.5% of sarcoid patients will develop hydrocephalus. Spinal cord and peripheral nerves are also susceptible to injury but are beyond the scope of the recent discussion. Approximately 97% of patients with neurosarcoidosis will have other systemic manifestations of sarcoidosis.[1]

Nodular sclerosis type Hodgkin's disease can cause bilateral hilar adenopathy and can cause pituitary and hypothalamic lesions but would almost always be associated with much more prominent mediastinal involvement. The fact that he has a history of a sexually transmitted disease raises the possibility of HIV infection that can be associated with central nervous system non-Hodgkin's lymphomas. HIV associated lymphomas generally pursue a much more aggressive course than this man has experienced and the appearance of the chest x-ray is very atypical. He has no other findings to suggest a diagnosis of AIDS, although testing for HIV infection is clearly indicated simply on the basis of his having had a sexually transmitted disease.

Tuberculosis is rarely a cause of bilateral hilar adenopathy. Nevertheless, tuberculosis can cause a basilar meningitis that can affect the pituitary and hypothalamus. This patient should have an intermediate strength tuberculin skin test followed by a second strength test if the intermediate is negative.

Coccidioidomycosis can cause hilar adenopathy but the adenopathy is generally unilateral and associated with definite lung infiltrates which this man did not have. Dissemination to the central nervous system is almost always in the context of immunosuppression. Furthermore, the patient had no history of travel to an endemic area. Approximately 5% of patients with blastomycosis will have central nervous system involvement but bilateral symmetrical hilar adenopathy would be extremely rare. Crypotococcosis frequently causes CNS disease but doe not cause bilateral hilar adenopathy. Histoplasmosis can disseminate to the CNS in the setting of immunosuppression and can cause exuberant lymph node enlargement in the mediastinum extending into the hilar area. This patient has predominantly hilar nodal involvement and has no known immunosuppression. For the above reasons, I think it unlikely that this patient had a fungal disease. Furthermore, the patient had negative fungal immunodiffusion tests.

Syphilis can cause a basilar meningitis or gummatous involvement of the hypothalamic-pituitary area: however, the adenopathy associated with syphilis is generalized and would not be essentially confined to the mediastinum and hila. The fact that the RPR was negative makes this diagnosis even less likely.

Having reviewed the main diagnostic considerations, I am convinced that this patient has sarcoidosis with both intrathoracic and central nervous system involvement. Confirmation of a diagnosis of sarcoidosis requires a compatible clinical picture, which this patient clearly had, and tissue for the histologic demonstration of noncaseating granulomas that show no evidence of tuberculous or fungal elements.

Several sources of tissue are available to support a diagnosis of sarcoidosis in this patient. Intrathoracic tissue is generally considered most nearly specific for the diagnosis of sarcoidosis and is generally obtained by transbronchial biopsy. Transbronchial biopsy can yield granulomas in about 60% of sarcoidosis patients who have normal lung parenchyma by chest x-ray. Mediastinoscopy would be an alternative. If he has ocular involvement, tissue may be available from the conjunctiva or lacrimal glands. The epitrochlear node is also readily accessible. If the hyperpigmentation of his scars is of recent onset, biopsy of a scar is likely to demonstrate characteristic granulomas. I would be inclined to do a punch biopsy of a scar but I suspect that this patient underwent transbronchial biopsy.

To reduce the unlikely possibility that he has a different disease affecting his pituitary-hypothalamic area, two additional studies are warranted, lumbar puncture and brain imaging with either CT or MRI. Spinal fluid will show abnormalities in approximately 50-60% of patients with CNS sarcoidosis, either a low order of mononuclear cells, a mild to moderate increase in protein, or a slightly low glucose. More importantly, microscopic examination and cultures can be done for tuberculous and fungal disease and cytologic studies can be done. CT or MRI will yield anatomical information about the CNS lesion and can assess for the presence of hydrocephalus.

Dr. Vickers: The initial chest x-ray has symmetrical hilar adenopathy. The nodes show up on the lateral film as well. The lung fields are essentially clear. The patient also had an MRI of the brain performed three days after admission. These images show asymmetric nodularity of the pituitary gland. The pituitary gland normally enhances. The pre-contrast does show some enhancement along the hypothalamic region. The pituitary stalk is large, thickened, and nodular appearing (Figure 2 and Figure 3).

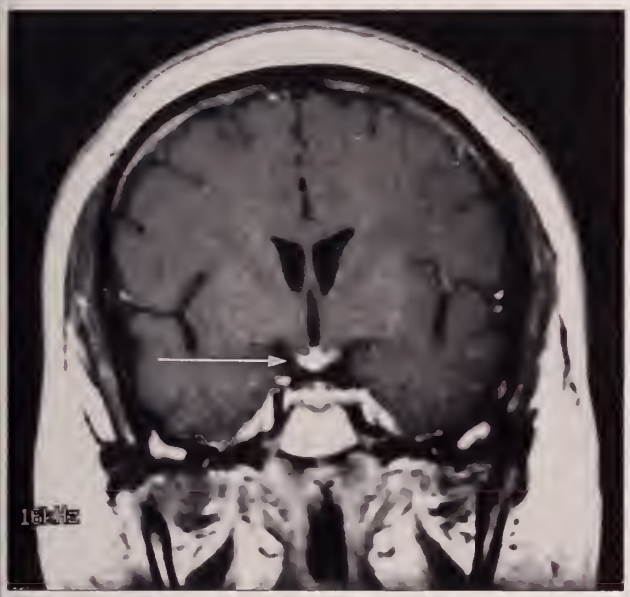


Figure 2: *Gadolinium enhanced coronal T_1 weighted MRI brain scan: Abnormal enhancement of hypothalamus.*

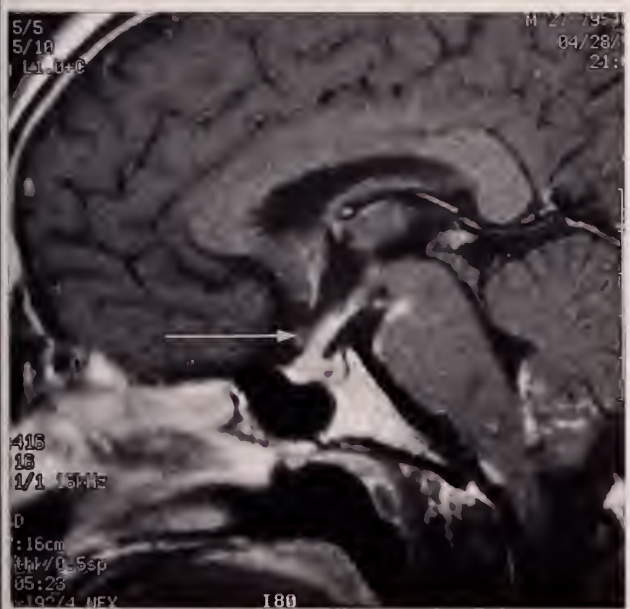


Figure 3: Gadolinium enhanced sagittal T_1 weighted MRI head scan: Shows abnormally thickened pituitary stalk and infundibular recess of third ventricle (hypothalamus).

Dr. Allen: In Pathology, we received a right epitrochlear lymph node that measured about 1.5cm in greatest dimension. On sectioning, the lymph node had a very homogeneous tan cut surface with no focal lesions. The consultation card stated the differential diagnosis included human immunodeficiency virus and lymphoma. Histologically, the lymph node architecture was almost completely replaced by noncaseating granulomas. Acid fast and fungal stains were negative.

Dr. Tarver: We have confirmed a diagnosis of sarcoidosis in this patient. Additional studies that should be obtained to aid in management are pulmonary function tests and ophthalmologic examination including slit lamp examination and visual fields. Angiotensin converting enzyme assays are not helpful in diagnosis but may aid somewhat in following therapy. Therapy, beyond replacement of the hormonal deficiencies, will consist of corticosteroids although three are no controlled trials of such treatment in nuerosarcoidosis.[1,2]

Diagnosis: Sarcoidosis. ❑

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1. Stern BJ, Krumholz A, Johns C, Scott P and Nissim J. Sarcoidosis and its Neurological Manifestations. Arch Neurol 1985;42:909-917.
2. Heck AW, Phillips LH. Sarcoidosis and the Nervous System. Neurologic Clinics 1989;7:641-654.

Dr. Files *is Professor of Medicine and Associate Chairman for Clinical Affairs, Department of Medicine.* ***Dr. Tarver*** *is Assistant Professor of Medicine, Department of Medicine;* ***Dr. Vickers*** *was Chief Resident in Radiology, 1993-1994 and* ***Dr. Allen*** *is Assistant Professor of Pathology, Department of Pathology; all at the University of Mississippi Medical Center, Jackson.*

Drs. Miller *and* ***Shakar*** *were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center, 1993-1994.*

What Does The Medical Alliance Do For Me?

George Neville

Well, that's kind of like asking what medicine does for me. Medicine is part of my life.

It is the way my wife serves humanity and earns a living at the same time.

It invades our home life with telephone calls, emergencies, disrupted schedules, and last-minute changes of plans.

It places us in the public eye, with an image to uphold, a reputation to maintain, and a responsibility to "give back" to the community.

It subjects us to certain dangers: the possibility of diseases such as AIDS and hepatitis; the threat of malpractice suits; the fear that government intervention will make her practice more burden than pleasure.

And, even though I have my own work, it provides a significant share of our income.

For these reasons, and more, what happens to medicine happens to us— my wife and to me.

My membership in the medical alliance is rewarding because it helps me deal with the challenges that are understood only by other medical family members. I've become friends with our colleagues in the profession— people who are there if we need them, sort of an extended family.

I've become educated about the problems of medical practice and how to deal with them. Conferences and publications help me know what we face as a family "partnership" and how I can help.

I've learned that the unique challenges of medical marriage can be managed, and understood, with appreciation for the rewards that accompany the stresses.

I've become part of an organization that is 100% dedicated to support the medical profession. Our projects are too numerous to list, but we are involved and effective in:

> AIDS education — Drug abuse education and prevention — Child abuse prevention — Support of candidates who share medicine's views — Support of legislation which helps to maintain the free and unfettered practice of medicine.

Okay, you say, but why does the medical alliance need male members? Why should you join? Here's why.

You have special expertise, talent, training, and contacts. We move in different circles from our female counterparts. We need you for what you can offer--to help us make a difference.

Medical school enrollment today is from 33% to 50% female. The volunteer force is changing. If you don't join us, medicine's strong right arm--its partnership with the alliance-could weaken and die.

You will benefit personally. You will strengthen your marriage, increase your circle of friends, and enhance your knowledge. You will also know that you support programs that make a difference to thousands of people.

I believe strongly in what we do in medical alliance, and I hope you will be a part of it too.

The author writes about himself — ***"I'm part of a new breed of activist for organized medicine. I'm involved in public service projects in my community, especially those which relate to the health and quality of life of our citizens. I'm married to a neurology resident in Jackson, Mississippi. I'm a proud Father. I'm an Army reservist. I'm an Attorney. I'm an active, involved officer of the medical alliance. And . . . I'm a man."***

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The President's Page

Mallan G. Morgan, MD

An Ethical Dilemma

"The old view that the principles of right and wrong are immutable and eternal is no longer tenable. The moral world is as little exempt as the physical world from the laws of ceaseless change, of perpetual flux." —Sir James Frazer

I have been trying, for several months now, to find a way to write a President's Page on medical ethics. My dilemma has been that I have been looking for a source that would summarize in a few sentences what is presently considered ethical medical behavior. I was unable to find that source. Dr. Helen Turner at The University Medical Center in Jackson referred me to an article in the March 3, 1993 issue of *JAMA* (Vol. 269, No. 9) by Edmund D. Pellegrino, M.D., entitled "the Metamorphosis of Medical Ethics; A 30 Year Retrospective". This article is a wonderful summary of the evolution of medical ethics, but does not provide an answer to what is ethical medical behavior today.

Dr. Pellegrino states that when he (and I) entered medical training in the mid 1960's, we were still in the period of the Hippocratic Ethic which had lasted 2,500 years. But in the mid '60's, Dr. Pellegrino believes that we moved to the Period of Principlism. Those principles being; nonmaleficence, beneficence, autonomy, and justice. There has since been a movement toward antiprinciplism theories: virtue based, caring based, and casuistry. But the future Dr. Pellegrino calls the Period of Crisis because of the atmosphere of skepticism and nihilism in which we live, along with the decline in the moral climate in the world today. This has resulted in the

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JOURNAL OF THE
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A Simpler Life Is What We Need

It had been a particularly hateful Monday in the clinic . . . you know the kind. At 5:30, over coffee with a friend, I announced that it was getting time I left to make some spaghetti for the boys. He remarked incredulously that a doctor shouldn't have to be bothered by such menial tasks, that I should nightly be able to arrive to a spotless home with a hot supper waiting on the table.

This is a tempting and not inconceivable notion. Don't think it hasn't crossed my circuits before. Unquestionably a physician's time is quite valuable. Perhaps what he implied was that I could stay in my clinic that extra hour and generate sufficient income to pay someone to come in and do all my "homework" for me.

But, somewhere along the line I seem to have gotten food and love hopelessly enmeshed together in my mind. Preparing food is a humble thing, an everyday thing, still it conveys so much.

I didn't bother to learn to cook or do much else of a domestic nature as young girls are supposed to do. Instead I possessed a greater affinity for following Daddy around the hog farrowing house, the corn fields or on various plumbing jobs every summer. Lucky for me the man I married had done a stint with the Waffle House so we didn't starve to death.

I have always known that my Mother is the WORLD'S BEST COOK. I carry with me substantial attestation to this fact, and I'm sure if you have any memories at all of your childhood you feel the same way. Even if your Mother made some really nasty oatmeal every morning, she made it for you, therefore in your eyes your Mom is "the WBC."

Out of necessity I learned to cook over the years. Nothing fancy mind you. And after all these years I've discovered what cooking really is - - a simple heart felt expression of love. Whether it is a plain old family meal or a big-do for a group of your friends, making that effort says "I really care about you!"

In that magic first hour after leaving behind the dramatic machinations of the office, your gears at once downshift to the routine chores of home. I have learned to revel in them. Preparing a meal requires a fair amount of concentrating and coordination. It is a worthwhile, goal-oriented activity which brings great pleasure to all concerned. When I come home from work and start supper there is no room in my mind for Serbia, O.J. or interest rates, arthritics, hypertensives or diabetics.

Sir William Osler once said, "No man is really happy or safe without a hobby, and it makes precious little difference what the outside interest may be - botany, beetles or butterflies, roses, tulips or

(continued on page 108)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(President's Page continued from page 106)

current confusion over ethical questions. This article is interesting and thought-provoking but does not answer the questions of: Is the medical decision that I make the ethically correct decision, is my relationship with my medical colleagues correct ethically, and how should I stand on some of the questions that now face the medical community?

There are so many specific and involved questions! Is physician assisted euthanasia ethical? Is the use of an anencephalic baby as a source for donor organs ethical? Or closer to home, is a generalist who treats patients for chest pain from 7AM to 11PM but at 2AM tells the emergency room to call the Cardiologist on call being ethical? Is changing the pattern of tests ordered for a certain diagnosis, to include one that is equally indicated but for which the physician is better compensated, ethical? There are too many questions and it seems that the more we try to answer specific questions, the more complicated any definition of Medical Ethics will become. And the more complicated it becomes, the more confusing it will be to the average physician (of which I am one) who has to make multiple ethical decisions daily.

Our dilemma is what do we use to make ethical decisions, assuming we want to, on a daily basis? The Webster's New World Dictionary defines ethical as "conforming to the standards of conduct of a given profession or group," implying that if the standard of the group is cannibalism then cannibalism would be ethical. Sir James, quoted earlier, might agree with this. But I think it is time to return to what worked for several centuries, The Hippocratic Ethic, and stop trying to micro-manage the question of medical ethics and modernize it. If it is right and moral for the patient, and right and moral for the physician, then it is right! We should add perhaps the tenet of the Golden Rule— "Do unto others as you would have them do unto you." Applying this along with the Hippocratic Oath should answer our questions on ethical behavior. Dr. Pellegrino concluded his summary with the statement "Medical ethics is too ancient and too essential a reality in the lives of physicians, patients, and society to be left entirely to the fortuitous currents of philosophical fashion or the unsupported assertions of clinicians." I agree but with the caveat that, as a clinician, I will assert that I will continue to believe in The Hippocratic Ethic and the Golden Rule.

Mal

P.S. I would like to extend my sincerest best wishes and those of the Board of Trustees to Mrs. Karen Stephens (the President of the MSMA Alliance) and her family, and let you know that all our thoughts and prayers are with you.

(Editorial continued from page 107)

irises, fishing, mountaineering or antiquities anything will do so long as he straddles a hobby and rides it hard."

I have actually come to think of cooking as a hobby, a kind of therapy if you will. It's fun trying to dream up ways to do it more efficiently and artistically. You can apply the same principle to whatever mundane tasks you have at home, yard work, auto maintenance, you name it. (Shopping doesn't qualify, however, all you are doing is buying more possessions that you'll need to work longer and harder to pay for.)

It's especially sad to see how hard a lot of doctors push themselves to accumulate new possessions, drive a fancier car, or live in a bigger house. Material wealth only rarely brings significant happiness, it usually only buys more expensive forms of misery. A simpler life is what we need.

My two boys are beginning to learn their way around in the kitchen a bit and I think that's pretty important. In too few short years they'll be grown up and gone. And when they've left and have homes and families of their own do you think I want then to remember their mama for the long hours she spent slaving away over a hot stethoscope? Not hardly. I want my children to remember me as "the WBC."

Dwalia S. South, MD
Associate Editor

Mississippi State Medical Association

OFFICIAL CALL
To: All Members of the Mississippi State Medical Association

The 127th Annual Session of the Mississippi State Medical Association is called to meet in Biloxi, Mississippi on Wednesday, May 17, 1995, pursuant to Article V of the Constitution.

The House of Delegates will be convened at the Treasure Bay Hotel at 9:00 AM on May 18. The Scientific Assembly will meet May 19 and 20.

No member or guest will be permitted to participate in any aspect of the Annual Session until regularly registered.

Mallan G. Morgan, MD, President
Candace E. Keller, MD, Secretary-Treasurer

127TH ANNUAL SESSION TREASURE BAY RESORT, BILOXI

MSMA's 127th Annual Session will be held at the Treasure Bay Resort Hotel in Biloxi, Mississippi, Wednesday, May 17 - Sunday, May 21. Individual room reservations should be made directly with the Treasure Bay Hotel prior to April 15, 1995. A room registration form was enclosed in the March *MSMA Report* and as a cover sheet with the March Issue of the *Journal MSMA*.

The **MSMA/MSMA Alliance Membership Party** will be held, on Thursday evening May 18, at 6:30 PM in the Crystal Room of the Treasure Bay Hotel. The MSMA Alliance will once again hold a silent auction with proceeds benefiting AMA-ERF. Association members and guests will be able to browse through the items for auction and make their silent bid during the party. The MSMA Membership Party is sponsored in part by Deposit Guaranty National Bank and will be hosted by the members of Singing River and Coast Counties Medical Societies and Alliances.

The annual **President's Party** will be held, Saturday evening May 20 in the Grand Casino Hotel in Biloxi, MS, in the Bay Ballroom from 6:00 PM to 7:45 PM. Members and their guests will have the opportunity to see this new hotel which will be the site of the 1996 MSMA Annual Meeting. Tickets will be provided for the 8:00 PM performance of "*Dancin' in the Streets*" in the Grand Theatre which is adjacent to the Hotel. This show features 21 of the hottest dancers, singers and magicians from around the world. This family-oriented production celebrates musical hits from the Big-Band Thirties to the Hip-Hop Nineties. The MSMA President's Party is sponsored by Trustmark National Bank.

HOUSE OF DELEGATES

The opening session of the House of Delegates will convene on Thursday, May 18, at 9:00 AM in the Crystal Room. Speaker of the House, Dr. Vann Craig of Natchez, requests that all delegates be certified and in place by 9:00 AM.

Delegates will hear an address by Dr. Robert E. McAfee, President of the American Medical Association. Dr. Mal Morgan, MSMA president will also address the House.

Reports and resolutions will be introduced at the initial meeting of the House for consideration by Reference Committees which will meet on Thursday afternoon. Please note that all reference committees will meet on Thursday afternoon.

The Reference Committee on Constitution and Bylaws will meet in rooms B, C, and D located on the second floor of the hotel at 2:00 PM. and will be immediately followed by Reference Committees A and B.

Delegates will reconvene on Sunday morning, May 21, to take action on policy recommendations and to elect MSMA officers for 1995-96. The installation of Dr. D. Stanley Hartness, of Kosciusko as MSMA 1995-96 president will mark the official conclusion of the 127th Annual Session.

MSMA 127th Annual Session and Scientific Assembly
May 17-21, 1995
Treasure Bay Resort Hotel • Biloxi, MS

PROGRAM OVERVIEW

WEDNESDAY, MAY 17

12:00	NOON	Physician's CPT Workshop (tentative)
1:00	PM	Exhibitor set-up: Technical & Scientific
		MSMA Registration opens

THURSDAY, MAY 18

8:00	AM	Exhibits Open - Continental Breakfast
		MSMA Registration
		MSMA Reference Committee Breakfast
9:00		MSMA House of Delegates
11:00		Alliance Preconvention Board Meeting/Luncheon
11:30		MSMA Member/Exhibitor Lunch in exhibit hall
		Committee on Publications Luncheon
1:00	PM	MS Foundation for Medical Care Membership Meeting
2:00		MSMA Reference Committee on Constitution and Bylaws
2:45		MSMA Reference Committee A
4:00		MSMA Reference Committee B
6:30		MSMA/ MSMAA Membership Party

FRIDAY, MAY 19

7:00	AM	Young Physicians Section - Continental Breakfast Business Meeting
7:30		MSMA Members and Exhibitors Continental Breakfast
		MS EENT Association Breakfast/Meeting
8:00		MSMA Registration
		Alliance Registration
		MSMA Past President's Breakfast
		MSMA Council on Medical Education
8:30		MSMA Medicine Plenary Session
8:45		MSMA Alliance House of Delegates
12:00	NOON	MS Academy of Family Physicians
		MS Psychiatric Association
		MS Neurological Society
		MS Chapter, American College of Emergency Physicians

FRIDAY, MAY 19 - Continued

1:30	PM	MACM Golf Tournament - Windance Country Club
2:30		MSMA Alliance Post-Convention Board Meeting
5:00		MSMA Past Presidents' Reception
6:00		Tulane University Medical Alumni Association
		University of Mississippi Medical Alumni Association Meeting
6:30		MACM Hospitality
9:00		MSMA President's Dessert Reception

SATURDAY, MAY 20

7:00	AM	Deep Sea Fishing
		MS Chapter, ACS, Officers and Board of Governor's Breakfast
8:00		MSMA Registration
8:30		MSMA Surgery Plenary Session
		MSMA Fifty Year Club Breakfast
		MSMA Alliance Past Presidents' Breakfast
9:00		MS Dermatological Society Meeting/ Luncheon
12:00	NOON	MS Chapter, American College of Surgeons
		MS Society of Anesthesiologists
		MS Association of Pathologists
		MS Society of Oncology
		MS Society of Plastic Surgery
3:00		MPIC - Annual Stockholders Meeting
3:30		Central Medical Caucus
6:00		MSMA President's Party

SUNDAY, MAY 21

7:30	AM	Membership Continental Breakfast
8:00		Protestant Services
9:00		MSMA House of Delegates
12:00	NOON	Meeting adjourns

EDUCATIONAL PROGRAM

PLENARY SESSION

Friday, May 19 • Room B

8:30 AM **Cooperative Risk Management: Survival for the Future**
JoAnn Bienvenu, R.N.C., B.S.N., Loss Prevention Consultant
Maryann B. Wee, R.N., B.S.N., Loss Prevention Manager
Medical Assurance Company of Mississippi
Lynda K. Plummer, R.N., M.B.A., Senior Risk Management Consultant
Mississippi Casualty Insurance Program

10:00 AM Break

10:15 AM **The Physician's Liability In Serving On HospitalCommittees**
George Ritter
Wise, Carter, Child and Carraway, Attorneys at Law

11:15 AM **Health Care Reform/Tort Reform and the Current Congress**
Jay Valasquez
AMA Department of Congressional Affairs

11:45 AM **Question and Answer Session**

Noon **Adjourn**

PLENARY SESSION

Saturday, May 20 • Room B

8:30 AM **The Big A and the 25 C's of Risk Management**
James Grant Thompson Memorial Lecture
Donald J. Palmisano, M.D., J.D.
Intrepid Resources, Metairie Louisiana

9:15 AM **Indemnity Issues in Managed Care Contracts**
Robin S. Palmisano, R.D., J.D., Director, Health Care Section
McGlinchey, Stafford, Lang, Attorneys-at-Law

10:00 AM Break

10:15 AM **Medical Panel of Experts: A Practice Effort for Professional Liability Reform**
Forrest D. Griffen, M.D.
Highland Clinic, Shreveport, Louisiana

10:45 AM **Liability and Laparoscopy**
Charles M. Dunn, III, V.P. Claims, C.O.O.
Maryann B. Wee, R.N., B.S.N., Loss Prevention Manager
Medical Assurance Company of Mississippi

11:15 AM **Panel Discussion**

12:00 **Adjourn**

Plenary Sessions Planned by the MSMA's:
Council on Scientific Assembly • Hospital Medical Staff Section • Young Physicians Section

TECHNICAL EXHIBIT

MSMA 127th Annual Session

EXHIBITOR	BOOTH
Abbott Laboratories	12
Amgen, Inc.	8
American Medical Recruiting Co.	45
Bedsole Medical Companies, Inc.	30
BFI	29
Bristol-Myers Squibb	27
Charter Hospital of Jackson	14
Coastal Physician Services	20
Dixieland Forest Products, Inc.	35
DPA, Inc.	42
Glaxo, Inc.	2
HealthCare Economics	22
IC Systems, Inc.	13
ICS, Inc.	38
Jackson Recovery Center	16
Knoll Pharmaceuticals	44
Medical Assurance Company of Mississippi	7
Medical Billing Associates	4
Medical Pathology Laboratory, Ltd.	34
Memorial Hospital at Gulfport	25
Merck Human Health Division	18
MetraHealth	24
Miles Inc./Bayer	37
Morehouse School of Medicine	10
MS Foundation for Medical Care	21
MS Methodist Rehabilitation Center	36
MS Physicians Care Network	32
MS State Department of Health	43
MSMA/MPIC	31
Pfizer Labs	48
Pine Grove	39
Puckett Laboratory	23
Salcris Systems	19
Section 170 Tax Program	33
Southern Medical Association	46
St. Paul Companies	47
Sta-home Health Agency	17
The Doctors' Company	28
The PIE Mutual Insurance Company	41
US Air Force Medical Recruiting	40
US Air Force Reserve	11
US Army Recruiting	26
US Navy Recruiting	5
Wilkerson Homes	15

Mississippi State Medical Association Alliance

72th Annual Session
May 17-21, 1995
Treasure Bay Resort Hotel
Biloxi, MS

WEDNESDAY, MAY 17

3:00 PM - 5:00 PM	Registration - 2nd Floor Lobby

THURSDAY, MAY 18

9:00 AM - 4:00 PM	Registration - 2nd Floor Lobby
11:00 AM	Pre-convention Board Meeting/Luncheon - Magnolia
1:00 PM - 4:00 PM	Wine & Cheese - View AMA-ERF Auction Items - Alliance Suite
6:30 PM	MSMA/ MSMAA Membership Party & AMA-ERF Auction - Crystal Room

FRIDAY, MAY 19

8:00 AM - NOON	Registration - 2nd Floor Lobby
8:45 AM	Continental Breakfast - Crystal Room
9:00 AM	House of Delegates
12:00 PM	Luncheon/ Installation of Officers
2:30 PM	Post-convention Board Meeting & Workshop Sharon Scott, Presiding, "Transition of New Officers"

SATURDAY, MAY 20

8:30 AM	MSMAA Past Presidents' Breakfast - Crystal Room
10:30 AM	Brunch and Fashion Show
6:00 PM	MSMA President's Reception - Grand Casino Hotel, Biloxi

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1995 Risk Management Discount Programs

Physicians who are eligible to participate in MACM's new risk management discount programs during 1995 will receive premium reductions in 1996. These programs will be presented from April through September 1995.

Risk Management in the Hospital Setting: MACM and the Mississippi Casualty Insurance Program, which insures the majority of hospitals in the state, will present this 90-minute cooperative program for MACM-insured physicians practicing in MCIP-insured hospitals.

Programs are currently being scheduled in numerous locations throughout the state including *Clarksdale, Columbus, Greenwood, Greenville, Gulfport, Hattiesburg, Jackson, Laurel, Meridian, New Albany, Oxford, Starkville and Tupelo*. Detailed registration information will be mailed to all MACM-insureds and published in upcoming issues of *The MACM Monitor* and the *MSMA Journal*.

Eligible physicians **(75% of their practice must be in a hospital insured by MCIP)** participating in these programs will receive a **10% discount**. A special program (CME credit available) will be presented on the morning of Friday, May 19th, for registrants at this year's MSMA Annual Session. *Physicians who do not meet the 75% requirement may attend these programs to qualify for the Basic 5% risk management discount mentioned below.*

Risk Management Basics: This 60-minute workshop, hosted by area hospitals, will focus on the current malpractice climate and associated risk management strategies. MACM insureds who participate will receive a **5% discount**.

If you have any questions regarding MACM's new programs and/or eligibility requirements, please feel free to call our Loss Prevention or Marketing Departments at 601-353-2000 or toll free at 1-800-325-4172.

5% Risk Management Basics Discount Program

Hospital	City	Date	Time
Magnolia Regional Health Center	Corinth	April 4	6:30pm
King's Daughters Hospital	Greenville	April 11	6:00pm
Southwest Regional Medical Center	McComb	May 8	7:00pm
Ocean Springs Hospital	Ocean Springs	May 18	6:00pm
Rankin Medical Center	Brandon	May 25	12:30pm
Singing River Hospital	Pascagoula	June 1	12:00Noon
		June 1	6:00pm
Methodist Medical Center	Jackson	July 12	12:00Noon
University of MS Medical Center	Jackson	July 18	4:00pm
		July 25	4:00pm
		September 18	4:00pm
Location To Be Announced	Natchez	Date/Time To Be Announced	

RESEARCHERS DEVELOP CERAMIC DRUG DELIVERY SYSTEM

Researchers at the University of Mississippi Medical Center (UMC) say drug administration can be cheaper, more effective, and have fewer side effects with a new device they developed. It is also being explored as an innovative means of treating AIDS, cancer and osteoporosis patients.

The ceramic drug delivery system (CDDS), which uses tricalcium- phosphate-lysine (TCP-L) implants, may replace the conventional method of drug administration for medications that have caused severe side effects, according to Dr. Hamed Benghuzzi, principal investigator and assistant professor of health sciences in UMC's School of Health Related Professions (SHRP).

He began research on the project in 1986 during his tenure at the University of Dayton and continues today in collaboration with researchers Dr. P.K. Bajpai of the University of Dayton and Dr. Barry England of the University of Michigan Medical Center.

According to Dr. Benghuzzi, it has been determined that the TCP-L implants are ready for clinical trials, and are a safer means of administering drugs and hormones, traditionally given orally or by injection.

Oral administration can result in degradation of the drug in the digestive tract. Several drugs administered orally can cause the patient mild reactions such as gastrointestinal disturbances to more involved nausea, diarrhea, electrolyte imbalance and anorexia.

When injected, "the drugs pass through the liver, and a large portion of the drug is destroyed. What actually gets to the site therefore is only a tiny bit of the drug." Also, drugs with short half-lives must be injected in multiple doses. This can result in trauma to the area of injection and is some times considered impractical because of the need of frequent injections. Thus, the traditional methods of drug administration mandate the use of higher doses to achieve effective results.

"Often, it is not the drug—as many people think—that causes side effects," Dr. Benghuzzi says. "It is the route of administration. With the ceramic devices, we can better determine if the drug or the means of administration actually causes the side effects. This will, in turn, provide us with an alternative to the conventional mode of administering medication."

According to Dr. Benghuzzi, TCP-L implants could solve the problem for those patients who have experienced severe side effects associated with the conventional modes of drug administration.

"Some AIDS patients cannot take drugs like AZT because of side effects such as diarrhea, vomiting, dizziness, and electrolyte imbalance," he explained.

Researchers believe the ceramic implant can be placed directly on tumors and effectively provide a complete cure for cancer patients who have complications resulting from chemotherapy.

"TCP-L devices have been proven to be an effective means of delivery for more than 50 drugs and combinations of drugs both in vitro and in vivo," said Dr. Benghuzzi. "This system can deliver proteins, amino acids, antibiotics, steroid hormones, nucleosides (such as AZT, used for AIDS patients), phenolics (fertility drugs), and enzymes at controlled levels for long periods of time."

TCP-L implants also can be surgically placed directly on or very near the target sites. The devices can be manufactured to deliver sustained amounts of various compounds for minutes or years, depending on the regulation of several factors such as density, biochemical property of medications, and surface area of the capsule, to name a few.

"With the TCP-L implants, physicians can supply the patients with medications within the therapeutic range for drug effectiveness. There is a tremendous reduction in the amount of the dose that is needed, and none of the drug is wasted. This is extremely important for drugs that are expensive or those with a short half-life," Dr. Benghuzzi pointed out.

The implants currently available, such as those manufactured

for sustained delivery of liquid medications or those used for birth control, have several drawbacks associated with their function, he says.

"These existing devices require refueling or recharging after a short period of time, are not adequate for delivery of most drugs for a long period, and must be used in multiple units to achieve the desired delivery," Dr. Benghuzzi said. "Most importantly, the devices are not biodegradable and require surgical removal, unlike the TCP-L implants."

The TCP-L device, patent pending, has not yet been approved for clinical use, but has been thoroughly tested in animals over long periods of time. Dr. Benghuzzi and other researchers are, however, anticipating clinical trials with the ceramic implant.

"That's our next step," he said. "The animal studies gave us the green light that these systems are effective, safe, won't induce any traumatic consequences because they are non-immunogenic, (the body won't reject), and proved to be highly acceptable by the host."

The TCP-L capsules were successfully used in animals comparable in size to humans to deliver a combination of drugs needed to regulate fertility in males and females longer than a year.

"This system should not be underestimated in its capability. It is able to deliver various medications individually or a combination of medications within one device," Dr. Benghuzzi said.

The devices also have been used extensively in the fields of endocrinology, as a means of overcoming endocrine dysfunction, and in the study of infectious diseases. "Because of the flexibility in preparation of the TCP-L implants a wider scope of use for these capsules is foreseen," he says.

He has captured the attention of his scientific peers at both the national and international levels with his work using ceramic devices to deliver, in a sustained manner, difluromethylornithine (DFMO), a drug used to treat African sleeping sickness.

Animals were implanted with the ceramic devices containing DFMO and were injected every 72 hours with 200 million Trypanosome brucei subspecies, the organism which causes sleeping sickness. The animals were completely cured and did not show any of the side effects associated with oral administration. Animals orally given DFMO, however, experienced severe diarrhea, severe fluid loss, and anorexia. Eventually, these animals died because of the parasitic infection.

Because African sleeping sickness makes some 10 million square miles of Africa useless for the breeding of livestock and poses a health threat to an estimated six million humans, Dr. Benghuzzi's research was important to the World Health Organization (WHO), Geneva Branch. Much interest has been expressed by WHO, he says, in employing the ceramic devices.

Dr. Benghuzzi comes to UMC with a diverse background. He holds the MS in biochemistry and a PhD in physiology, along with a four-year fellowship in pathology and a secondary appointment in the Department of Pathology at UMC. He continues to advance the ceramic system and has established collaborative efforts in UMC's Schools of Medicine and Dentistry.

In other joint efforts, Dr. Benghuzzi has sparked the interests of Dr. L. Lemos, associate professor of pathology, and Zelma Cason, chairman of the Department of Cytotechnology. Together, the three are evaluating the cellular mechanisms associated with the degradation of the TCP-L implants.

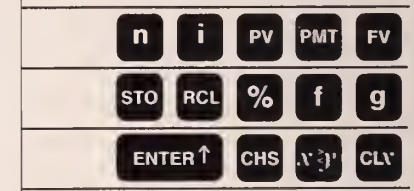
Currently, Dr. Benghuzzi also is working with UMC's orthopedic team, including Dr. Audrey Tsao, assistant professor of orthopedic surgery, and Shelley Tucci, senior research scientist, in an effort to deliver antibiotics and growth enhancing compounds to traumatized bone.

In addition to the recognition received from WHO, Dr. Benghuzzi has received several awards and honors from various scientific societies, including the Diploma of Excellence for the Academy of Surgical Research, the Young Investigator Award from the Endocrinology Society, and the Presidential Award from the Scanning Electron Microscopy Society. He also has presented his findings at

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various national and international meetings, and was recently elected to the Board of Directors at the Rocky Mountain Bioengineering Society, where he will serve as chairman of the program during the 1997 meeting.

"Dr. Benghuzzi is encouraged to continue these efforts in performing up-to-date research at UMC," said Dr. Owen Elder, chairman of the Department of Health Sciences. "SHRP has been strictly teaching oriented since its inception 25 years ago, but now, under the direction of Dr. Maurice Mahan, dean, we've begun to make more of an effort towards research. Dr. Benghuzzi is an example of SHRP's administrative efforts to recruit professors who can teach and concentrate on serious scientific research. This research will simply add another level of sophistication to SHRP as an allied health school in the health care profession."

"My greatest hope is that this device can be used as a targeted delivery system for specific sites," Dr. Benghuzzi said. "I want the TCP-L implant to be given the chance to perform to its fullest capabilities as a safe alternative to the current methods of drug therapy." ❑

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AMRA, NASIR K., Hattiesburg. Born Youngstown, OH, May 19, 1961; MD, Ohio State University College of Medicine, Columbus, OH, 1986; pathology residency, Ohio State University Hospital, Columbus, OH, 1987-91; elected by South Mississippi Medical Society.

BAILLIO, EMILY R., Jackson. Born September 18, 1965; MD, University of South Alabama School of Medicine, Mobile, AL, 1991; internal medicine residency, same, 1992-94; elected by Central Medical Society.

BARBER, WILLIAM H., Jackson. Born Utah, November 11, 1953; MD, University of Florida College of Medicine, Gainesville, FL, 1979; interned one year, University of Alabama, Birmingham, AL; surgery residency, Oxford University, England, 1981-84; surgery residency University of Alabama, Birmingham, AL, 1984-87; elected by Central Medical Society.

CODY, J. ANTHONY, Jackson. Born Jackson, MS, August 29, 1965; MD, University of Mississippi School of Medicine, Jackson, MS, 1991; family medicine residency, same 1991-94; elected by Central Medical Society.

FINCH, JON DAVID, Jackson. Born Lansing, MI, June 12, 1963; DO, Kansas City College of Osteopathy & Surgery, Kansas City, MO, 1990; emergency medicine residency, Chicago Osteopathic Hospital, Chicago, IL 1991-94; elected by Central Medical Society.

FLAUTT, F. HENRY, JR., Greenwood. Born Greenwood, MS, December 6, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine residency, Same, 1991-94; elected by Delta Medical Society.

GOODFELLOW, KEITH G., Bay St. Louis. Born New Orleans, LA, May 19, 1961; MD, Louisiana State University School of Medicine, New Orleans, LA., 1990; ob-gyn residency, same & Charity Hospital, New Orleans, LA, 1990-94; elected by Coast Counties Medical Society.

HANCOCK, J. CHRIS, Natchez. Born Greenwood, MS, March 14, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; pathology residency, same, 1988-92; fellowship surgical pathology & hematopathology, University of Alabama Hospital, Birmingham, AL, 1992-93; elected by Homochitto Valley Medical Society.

HANNA, SHAHIRA, Biloxi. Born Egypt, September 1, 1959; MD, University of Pennsylvania School of Medicine, Philadelphia, PA, 1985; ob-gyn residency, State University of New York Upstate Medical Center, Syracuse, NY, 1981-83 & Hahnemann University Hospital, Philadelphia, PA, 1985-89; elected by Coast Counties Medical Society.



HAUSER, CARL JEFFERY, Jackson. Born New York City, NY, April 15, 1948; MD, New York University School of Medicine, New York, NY, 1977; interned one year and surgery residency, Harbor/ UCLA Medical Center, Torance, CA, 1978-83; fellowship surgical critical care, same 1977-78; elected by Central Medical Society

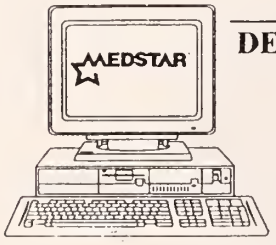
KRAMER, JAMES J., Brandon. Born South Bend, IN, February 24, 1947; MD, Loma Linda University School of Medicine, Loma Linda, CA, 1977; internal medicine residency, same, 1977-80; elected by Central Medical Society.

KRATZ, KURT G., Hattiesburg. Born Swreoir, MI, May 25, 1960; MD, Wayne State University School of Medicine, Detroit, MI, 1986; pathology residency, William Beaumont Hospital, Michigan, 1987-88, The Children's Hospital, Denver, CO, 1989-90, University of Colorado Health Sciences, Center, Denver, CO, 1990-91; cytopathology fellowship Medical College of Pennsylvania, PA, 1991-92; elected by South Mississippi Medical Society.

MCDOWELL, DOUGLAS A., Pascagoula. Born Iron Mt., MI, July 17, 1956; MD, Wayne State University School of Medicine, Detroit, MI, 1984; interned one year SMAHEC, Kalamazoo MI, general medicine residency, USAF 1985-89; emergency residency, Ft. San Houston, TX, 1990-92; Keesler AFB, 1992-94; elected by Singing River Medical Society.

ROBERTS, JAMES E., JR., Brookhaven. Born Orange, CA, March 5, 1965; MD, University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine residency, Same, 1991-94; elected by Central Medical Society.❑

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Meetings

NATIONAL AND REGIONAL

American Medical Association — Annual Meeting, June 17-22, 1995, Chicago, IL; Leadership Conference, March 26-29, 1995, Washington, DC; Interim, December 3-6, 1995, Washington, DC. James S. Todd, MD, Executive Vice President, 515 N. State St., Chicago, IL 60610

STATE AND LOCAL

Mississippi State Medical Association — Annual Meeting, May 17-21, 1995, Biloxi, Charles L. Mathews, Executive Director, 735 Riverside Drive, PO Box 5229, Jackson 39296-5229.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December, James S. Poole, MD, Secy., The Gloster Clinic, PO Box D, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Mrs. Patsy Douglas, Executive Secy., 735 Riverside Dr., Jackson 39202. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale, Glen L. Wegener, MD, Secy., PO Box 430, Clarksdale, 38614-0430. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, March, June, and November. James E. Clarkson, MD, Secy., Mail: Ms. Leslie Johnson, PO Box 128, Biloxi 39533. Counties: Hancock, Harrison.

Delta Medical Society, 2nd Wednesday, April and October. A. Randle White, MD, Secy., 609 Tallahatchie St.,Greenwood, 38930. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, MD, Secy., PO Box 5025, Meridian 39302. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society. Meetings scheduled quarterly, David G. Hall, MD, Secy., 150 Jeff Davis Blvd, Suite 130, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January, Robert H. Curry, MD, Secy., 500 Hwy 9 S, Eupora 39744. Counties: Attala, Carroll, Choctaw, Granada, Holmes, Montogomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Richard L. Heyer, Jr., MD, Secy., Mail: Ms. Shirley Irwin, PO Box 3294, Tupelo 38803-3294. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, and 3rd Thursday, January. Philip R. Loria, Jr., MD, Secy., 2200 S. Lamar Blvd, Ste E., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Prairie Medical Society, 2nd Tuesday, March, June, September, December,Steve Brandon, MD, Secy., 501 Hospital Rd., Starkville 39759. Counties: Clay, Oktibbeha, Noxubee, Lowndes.

Singing River Medical Society, Quarterly, December, March, June and September. Hal Moore, MD, Secy., Mail: Mrs. Lujean Trumble, P. O. Box 231, Pascagoula 39568-023. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Jr., MD, Secy., PO Box 1910, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. William A. Whitehead, MD, 415 South 28th Ave., Hattiesburg 39401-7246. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, May, September, November, 6:30 p.m. Maxwell's Restaurant, Vicksburg. Daniel Edney, MD, Secy., PO Box 231, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited to Sponsor Intra-state Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials of the Accreditation Council for Continuing Medical Education (ACCME)" and the Council on Medical Education of the MSMA. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39202-1166

North Mississippi Medical Center
830 Gloster Street
Tupelo, MS 38801

Forrest General Hospital
Mamie Street and Highway 49 South
Hattiesburg, MS 39401

Mississippi Baptist Medical Center
1225 N. State Street
Jackson, MS 39202

Gulf Coast Community Hospital
180 DeBuys Rd.
Biloxi, MS 39531

Natchez Regional Medical Center
Seargeant Prentiss Drive
Natchez, MS 39120

King's Daughters Hospital
Highway 51 North
Brookhaven, MS 39601

Biloxi Regional Medical Center
150 Reynoir St.
Biloxi, MS 39533

Jeff Anderson Regional Medical Center
2124 14th St.
Meridian, MS 39301

Methodist Medical Center
1850 Chadwick Dr.
Jackson, MS 39204

Grenada Lake Medical Center
960 Avent Drive
Grenada, MS 38901

Baptist Memorial Hospital - Golden Triangle
2520 Fifth St., North
Columbus, MS 39701

Northwest Mississippi Regional Medical Center
Hospital Dr.
Clarksdale, MS 38614

Singing River Hospital
2809 Denny Ave.
Pascagoula, MS 39567

Greenwood Leflore Hospital
1401 River Rd.
Greenwood, MS 38930

Memorial Hospital at Gulfport
4500 13th St.
Gulfport, MS 39501

Baptist Memorial Hospital of North Mississippi
Highway 7, South
Oxford, MS 38655

St. Dominic-Jackson Memorial Hospital
969 Lakeland Dr.
Jackson, MS 39216

Delta Regional Medical Center
1400 E. Union St.
Greenville, MS 39704

Methodist Hospital
5001 W. Hardy St.
Hattiesburg, MS 39401

MS State Department of Health
PO Box 1700
Jackson, MS 39215-1700

Rush Foundation Hospital
1314 19th Avenue
Meridian, MS 39301

Charter Hospital of Jackson
East Lakeland Drive
Jackson, MS 39296-4297

Gene R. Barrett, of Mississippi Sports Medicine, Jackson, recently published two articles on anterior cruciate ligament reconstruction in the *Journal of Knee Surgery* and attended the Accu-fex knee study group at the American Academy of Orthopaedic Surgeons in Orlando, Florida.

J. Patrick Barrett has been elected Chief-elect of the Medical Executive Committee of the Medical Staff at St. Dominic-Jackson Memorial Hospital, Jackson.

Deaver Collins of the Medical Clinic, PA, Jackson, recently served as a member of the faculty for the 18th Annual Gold Coast Conference on Medicine, Pediatrics and Obstetrics/Gynecology which was accredited by The Good Samaritan Medical Center in West Palm Beach Florida. He spoke on the topic, *Anticardiolipin Antibodies*.

Jeff A. Fletcher has been elected Secretary of the Medical Executive Committee of the Medical Staff at St. Dominic-Jackson Memorial Hospital, Jackson.

Eugene B. Ferris, III, an Ohio native, joined the staff of the Vicksburg Clinic in February specializing in general and vascular surgery.

Larry D. Field, a new orthopaedic surgeon in Jackson and partner with Mississippi Sports Medicine and Orthopaedic Center, recently presented three research projects on the shoulder and elbow and



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AIR FORCE

was moderator for the scientific session on "Shoulder Disorders" at the American Academy of Orthopaedic Surgeons' meeting in Orlando, Florida.

Thomas P. Forks, will join the staff of the Walnut Grove Medical Clinic in Walnut Grove and is associated with East Central Mississippi Health Care, Inc.

Elizabeth Connell Henderson has associated with LaurelWood Center in Meridian for the practice of general adult and addiction psychiatry.

James R. Haltom has received his board certification in Pediatric Pulmonary. He is associated with the MS Asthma and Allergy Clinic, PA, 940 N. State Street, Jackson.

J. Edward Hill, a board certified family practice physician, is serving as Residency Director of North Mississippi Medical Center's Family Medicine Residency Program and will see patients in the Family Medicine Center, Tupelo.

Candace Keller, of Hattiesburg, MSMA's secretary-treasurer and alternate delegate to the AMA will attend the American Political Action Committee Campaign School in Washington, D.C., March 22-26. The Campaign School teaches physicians and their family members how to participate in the election process and public administration.

Henry Allen McCrory, of Clarksdale, has been recertified a Diplomate of the American Board of Obstetrics & Gynecology.

James McIlwain, Jr., of Clinton, has been recertified a Diplomate of the American Board of Family Practice.

Shanti Pandey, of Fayette, has been recertified a Diplomate of the American Board of Family Practice.

Kamlesh H. Parekh, of Senatobia, announces the opening of his Internal Medicine practice, 103 McKie St., Senatobia.

Daniel Q. Richardson, of Gulfport, has been certified by the American Board of Plastic and Reconstructive Surgery.

James Edward Ruff announces the opening of his practice in General Psychiatry, 1203 Broad Avenue, Suite B, Gulfport.

Rebecca Buchanan Saenz has joined the faculty of the University of Mississippi Medical Center as an assistant professor of family medicine.

Henry B. Tyler has been elected Chief of Staff of the Medical Executive Committee of the Medical Staff at St. Dominic-Jackson Memorial Hospital.

Abelardo S. Wee has associated with Rush Medical Group, PA, Meridian for the practice of Neurology. ❑

Physicians' Recognition Award



Three MSMA members were named recipients of the AMA Physicians Recognition Award in January and February, 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

CENTRAL MEDICAL SOCIETY

Phillip K. Blevins, MD
Suman K. Das, MD
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Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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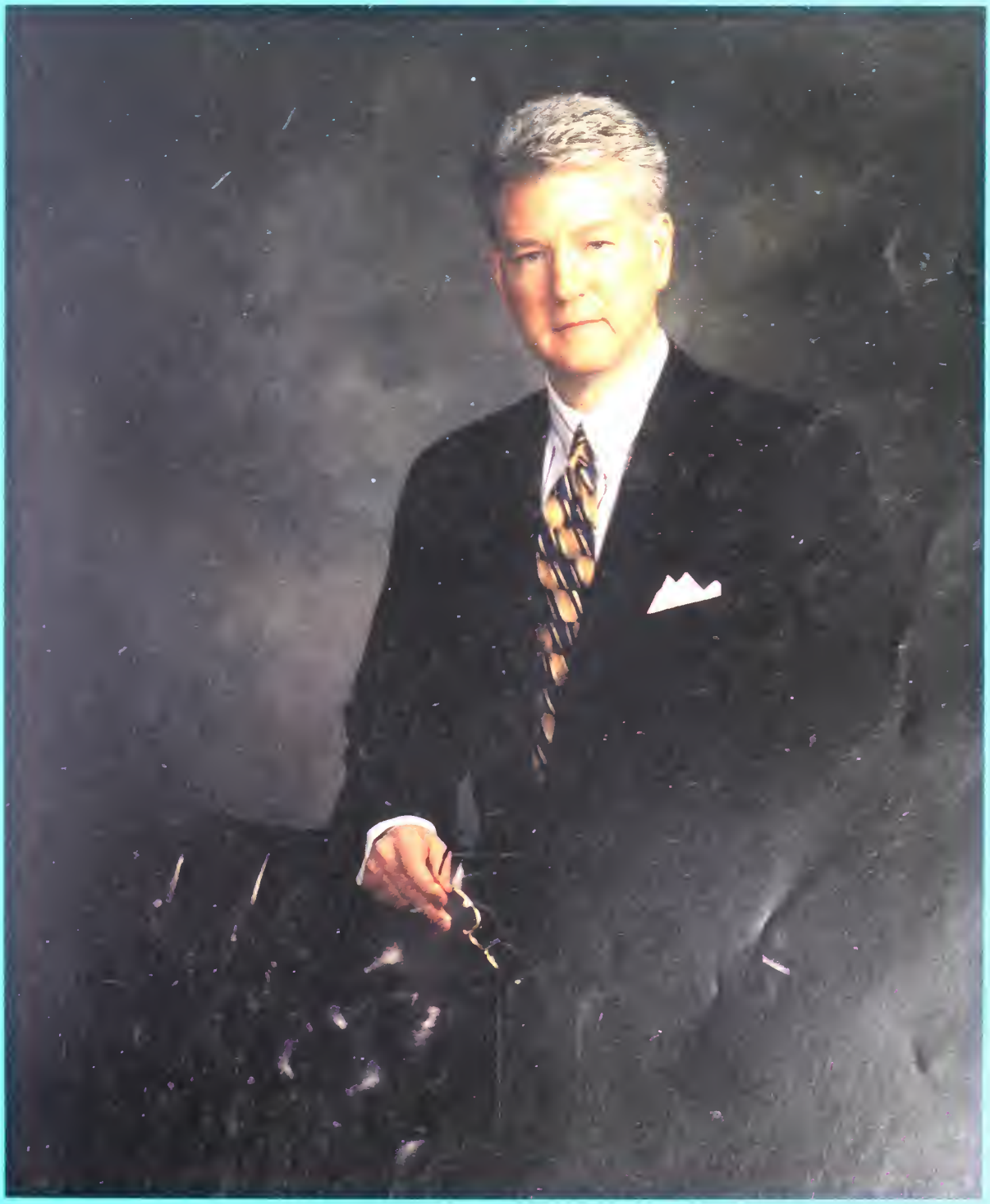
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OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

MAY 1995



D. Stanley Hartness, Jr., M.D. — 1995-96 MSMA President



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STD ALERT

Jackson, MS— Mississippi has the highest rate of primary and secondary syphilis in the country at 81 per 100,000 population for 1994. This is 10 times the national average and 8 times the year 2000 objectives for the nation. We also had the highest number of cases of primary and secondary syphilis in the country for last year.

Please beware that primary syphilis chancres can look just like herpes lesions, and will heal even if untreated, although the syphilis infection persists. The genital lesions caused by chancroid can also appear very like syphilis chancres. Chancroid is an STD thought to be rare in this country. However, it was diagnosed, with the help of the Centers for Disease Control and Prevention, in 45% of the persons presenting to the Ellis Avenue STD Clinic with genital ulcers in the fall of 1994. It is recommended that persons in the Jackson area with genital ulcers that are not obviously due to herpes, be treated for both syphilis and chancroid.

The secondary syphilis rash can be easily mistaken for other skin conditions for which the patient seeks dermatologic care.

One consequence of the massive increase in syphilis rates is the large number of congenital syphilis cases seen in the past 2 years. There were 69 cases reported in 1993, and 56 in 1994. Because of the epidemic, we recommend all maternity patients be screened for syphilis at their first prenatal visit and early in the third trimester, as well as at delivery. If the patient is considered to be high risk, additional screening at 20 - 24 weeks should also be considered. The only appropriate therapy for syphilis during pregnancy is penicillin.

Another reason controlling the outbreak is so important is that HIV transmission is made more efficient by the presence of a primary syphilis chancre. The prevalence of HIV infection among persons seen in the Ellis Avenue STD Clinic with genital lesions has skyrocketed in the past year.

All cases of syphilis are reportable to the State Department of Health (MSDH). All persons with syphilis of less than one year's duration are interviewed to elicit sexual contact information. All contacts are treated preventively, and currently, all possible contacts are offered treatment. Personal identifying information is kept confidential. The source of the information is not revealed to the person being interviewed and offered preventive therapy.

MSDH is also increasing availability of treatment for syphilis in the county clinics. The STD Clinic at Ellis Avenue is being restructured to allow for better patient flow and response to walk-in patients.

The February issue of the *Mississippi Morbidity Report* contains treatment information. Please call your local Health Department, or the Health Department Central Office (STD/HIV Division, 960-7714, Epidemiology Office, 960-7725), with questions, comments or reports. ❑

Proceedings from the Fourth Annual St. Dominic's Winter CME Multi-Specialty Conference

Park City, Utah
February 4-7, 1995

From February 4 through February 7, 1995, St. Dominic Hospital convened its Fourth Annual Winter CME course. Since the course's inception in 1991, attendance has grown each year and in 1995 the conference was attended by 44 physicians, 9 administrators, and approximately 50 spouses and children. This course originated with the idea that physicians are interested in what other physicians are doing, even if it is in an unrelated specialty. Our topics have spanned the spectrum of medicine and talks are presented in the form of didactic lectures each morning followed by a day on the slopes with colleagues and family. In the evening, forums are presented which center around health care in general, and these usually involve physicians and administrative staff.

The information presented is timely and what follows are some of the summaries presented by our lecturers. You will recognize the names as practicing physicians rather than "experts with a national reputation." Hopefully, these reviews are of value to the practicing physician in Mississippi.

We invite you to consider attending the Fifth Annual St. Dominic Winter CME Multispecialty Conference to be held in early February, 1996. Further information will be published in this journal and can be otherwise obtained by writing to Ms. Anne Nelson, Vice-President, Administrative and Medical Staff Services, St. Dominic/Jackson Memorial Hospital, 971 Lakeland Drive, Jackson, 39216.

James S. Jones, M.D.
Course Chairman

CANCER SCREENING IN THE 90'S

Holland M. Addison, Jr., MD

A key function of every primary care practitioner is early disease detection. As cancer remains the number two killer in the United States, following heart disease, cancer screening therefore becomes a major responsibility that we physicians take on. The periodic health examination is probably still the major setting in which we are allowed to interact with patients to help screen for malignancies, taking multiple factors into consideration, including age, race, gender, family history, associated diseases, and toxic exposures, to name a few. We

must also understand the incidence of the diseases for which we are screening, and understand whether screening can be justified, based on the outcomes of our screening. The Pap smear, for example, has been highly effective in reducing the incidence of deaths from cervical cancer, whereas there is no effective means of screening for pancreatic cancer and many other malignancies.

Let's first begin by looking at the incidence of the three most common cancers in males and females. In males, prostate cancer makes up 32% of all detected cancers, lung cancer makes up 16%, and colorectal cancer, 12%.

In females, breast cancer accounts for 32% of all cancers detected, while lung cancer at 13% and colorectal cancer at 13% follow.

When we speak of the death rate from cancer. however, the statistics change. In males, lung cancer accounts for 33% of cancer deaths, prostate cancer accounts for 13%, and colorectal, 10%. Among females, lung cancer accounts for 23% of cancer deaths, breast cancer accounts for 18%, and colorectal, 11%.

The conditions that a disease must meet in order to justify screening are summarized below:

1. The condition must have a significant effect on the quality or length of life.
2. Acceptable methods of treatment must be available.
3. The condition must have an asymptomatic period during which detection and treatment significantly reduce morbidity or mortality.
4. Treatment in the asymptomatic phase must yield a therapeutic result superior to that obtained by delaying treatment until symptoms appear.
5. Tests to detect the condition in the asymptomatic period must be acceptable to patients and must be available at a reasonable cost.
6. The incidence of the condition must be sufficient to justify the cost of screening.

Skin Cancer

Skin cancers are among the most common malignancies, and like other malignancies, their incidence increases markedly with age. In 1991, approximately 60,000 new cases of skin cancer were diagnosed, and 8,500 deaths resulted from skin cancers. The most common types are basal cell, squamous cell carcinoma and malignant melanoma. Sun exposure is a major factor in all three types of malignancies. The incidence of and death rate from melanoma are increasing significantly in the United States, having doubled in the last decade. The prognosis is linked closely to the extent of disease at diagnosis. The American Cancer Society does recommend a complete skin examination as part of the routine periodic health examination, but the U.S. Preventive Services Task Force, or USPSTF, and the Canadian Task Force only recommend skin examinations for patients at high risk.

Oral Cancer

Oral cancers have a peak incidence between ages 55 and 75. There are 30,000-50,000 new cases diagnosed each year. Men are seven times more likely than women to develop oral cancer, and these cancers have been associated with the heavy use of alcohol, cigarettes, and smokeless tobacco. Both the USPSTF and the ACS recommend annual examination, particularly in high risk patients.

Thyroid Cancer

Thyroid carcinomas occur in four out of every 100,000 people. The risk factors include a young age, usually less than forty years, male sex, history of head or neck irradiation in childhood, family history of thyroid carcinoma, pheochromocytoma and/or hyperparathyroidism (MEN Type II).

Lung Cancer

Lung cancer remains the leading cause of cancer deaths for both men and women in the United States. The two primary screening strategies used to detect lung cancer in the past have been that of chest radiographs and sputum cytology. Unfortunately, neither of these tests have proven efficacious in mass screening, and therefore are not recommended by any group at the present time. The Mayo Lung Project, completed in 1991, did demonstrate increased detection rate among high risk patients. However, there was no proven reduction in mortality. A Japanese trial, involving 305,934 patients studied between 1987 and 1989, did report a seventy percent sensitivity using 100 mm photofluorograms compared to forty five percent using the standard chest x-ray in the National Cancer Institute's Early Lung Cancer Trial. This study and others have prompted the National Cancer Institute to begin a new multiphasic screening trial, which was begun in 1993, and currently involves 148,000 patients, age 60-74. It is hoped that this trial will settle the controversy about the benefits of chest x-ray for lung cancer screening.

Breast Cancer

Breast cancer screening has probably attracted more public awareness than any other disease process that we currently screen for. The USPSTF guidelines

recommend an annual mammogram and clinical breast examination beginning at age 50, but clarify that evidence is soft regarding the benefit of clinical breast examination and questioned the effectiveness of cancer screening past age 70. The American Cancer Society, which has the most liberal approach of cancer screening methods, recommends self-examination for all females beginning at age 20, which should be done on a monthly basis. Clinical breast examination should begin at age 20 and be conducted every three years until age 40, then every year thereafter. Mammography should begin at age 40 with annual examinations, and extending for the lifetime of the patient. The Canadian Task Force does recommend annual breast examinations between age 50 and 70, but not beyond.

There has been much controversy regarding the screening of women between ages 40 and 49. A large Canadian study, published in the Canadian Medical Association Journal in 1992, found that annual mammography in patients aged 40 to 49 did not reduce breast cancer deaths during an average of 8.5 years. Based on this study and others, the National Cancer Institute in early 1994 published guidelines for mammography. For ages 40 to 49, they stated that there is insufficient evidence to make an informed decision regarding screening in women ages 40 to 49. For ages 50 to 69, there is strong evidence that screening on a regular basis is effective. For women ages 70 and older, they stated that clinical trials offer no information. The risk of disease increases with age and there is no known upper age limit at which screening ceases to be effective. It would appear that this controversy would not be resolved in the near future, and unless health care reforms or insurance coverage restrict mammography, that individual decision will have to be made by each patient along with the best advice and information supplied by the physician.

Colorectal Cancer

Colorectal cancer screening is encouraged, with the American Cancer Society recommending a stool guaiac on a yearly basis for all patients over the age of fifty. They also recommend sigmoidoscopy every three to five years, based on the advice of the physician for patients over the age of fifty. Neither the Canadian Task Force nor the USPSTF found enough evidence to recommend for or against fecal occult blood testing or sigmoidoscopy. Colonoscopy as a screening tool is indicated only for certain high risk groups, which would include: (1) ulcerative colitis, (2) cancer-family syndrome, (3) previous polyps or colon cancer, or (4) history of endometrial, ovarian or breast cancer.

Prostate Cancer

Prostate cancer screening has also become somewhat controversial. For a number of years the American Cancer Society has recommended digital rectal examination, which carries an overall accuracy rate of about 58%, beginning on an annual basis at the age of forty. Neither the Canadian Task Force nor the USPSTF have recommended this procedure. The prostate specific antigen, however, which gives an overall accuracy rate of about sixty-four percent as a screening tool, is recommended now by the American Cancer Society and the American Urological Association to begin yearly at the age of fifty. An article published by Krahn, M.D., *et al*, in *JAMA*, September 1994, concluded that screening programs produced only a small gain, one to two days in average life expectancy, but the economic costs were great, and therefore screening for prostate cancer cannot be justified as a rational health policy. This has sparked much debate in the literature. However, I do believe PSA screening has become standard in most clinicians offices, and is a frequently requested procedure by patients who are interested in early disease detection. Transurethral ultrasound is not considered a screening tool, but is used only for abnormal digital rectal examination or PSA's greater than 4.

Cervical Cancer

Cervical cancer continues to be a major health problem for women, with approximately 14,000 new cases and 5,000 deaths occurring annually. The natural history of cervical cancer and the development of the Papanicolaou smear in the 1940's made cervical cancer an ideal candidate for periodic screening. The American Cancer Society recommends beginning Pap smear testing at age the age of 18, then annually until a woman has had three normal tests. Subsequent screening frequency is left to the discretion of the physician. The USPSTF recommends every one to three years, beginning at the onset of sexual activity, until the age of 65, when screening should be discontinued if previous smears have been consistently normal. The National Institutes of Health recommend screening be discontinued at age 60 if two negative Pap smears have been obtained. The Canadian Task Force recommends annual screening for ages 18 to 35, then testing every five years until age 60, at which time screening is stopped. Routine screening for endometrial cancer is not recommended.

Ovarian Cancer

Ovarian cancer is the leading cause of death among gynecologic cancers, with 21,000 new cases each year, and 13,000 deaths. The five year survival rate for early stages is 85%, and only four percent in advanced cases. The only screening procedures for asymptomatic women including bimanual pelvic exam, CA-125, and pelvic ultrasound, have not proven effective, and the American College of Obstetrics and Gynecology has recommended against routine screening. There is some debate in the literature about the evaluations of those patients who are considered high risk, that is, with a strong family history of ovarian cancer. However, there are no current guidelines published at the present time.

To conclude, effective cancer screening remains a very difficult problem in clinical practice, both for the physician whose job it is to recommend proven and effective screening techniques, and for the patient who is interested in disease prevention. Ongoing clinical studies should help to establish more recommended protocols in the future. ❑

A MISSISSIPPI EPIDEMIC: THREE CASES OF GASTRIC SYPHILIS

Billy W. Long, MD

The incidence of syphilis has recently increased to epidemic levels in many U.S. cities, probably because of the significant rise in drug use, especially crack cocaine, and prostitution related to this drug trade. Twenty-five cases of gastric syphilis have been reported in the English literature during the past 50 years, but few cases were reported in the three decades between 1955 and 1985. However, in the past decade over 15 patients with gastric syphilis, have been described. During 1994 the author has seen three patients with gastric syphilis at one hospital in Jackson. This indicates that the syphilis epidemic has spread to the rural South. In fact, Mississippi has experienced a syphilis epidemic during the past five years. The syphilis case rate in Mississippi during 1993 was six times the national average (68.4 versus 10.6 cases per 100,000 population). This report is intended to raise the index of suspicion by the practicing clinician for syphilis as a cause of upper gastrointestinal disease.

These three patients with gastric syphilis were 27, 29 and 33 years of age. One was female. They all complained of abdominal pain, nausea, vomiting, and weight loss. Two reported having hematemesis. Upper gastrointestinal endoscopy revealed gastric ulcers in the antrum with large edematous folds, and friable, nodular mucosa. The gross appearance suggested lymphoma or other malignant conditions. Endoscopic biopsies showed a dense lymphocytic infiltrate with atypical lymphocytes. Lymphoma was suspected. Spirochetes were seen on Warthin-Starry stain in two patients. One patient had a partial gastrectomy because of intractable symptoms, and spirochetes were then found in the surgical specimen. All three patients were negative for the HIV antibody, and one patient had concomitant Helicobacter pylori gastritis. The VDRL and FTA-ABS tests were positive in all three patients. They all responded to treatment with Benzathine Penicillin, 2.4 million units intramuscularly weekly for three weeks. Symptoms usually resolved within weeks.

Gastric syphilis may be confused with Menetrier's disease, hypertrophic gastritis, MALT lymphoma, non Hodgkin's lymphoma and linitis plastica carcinoma. The clinician must include syphilis in the diagnosis of upper gastrointestinal pathology, and obtain tests such as the VDRL and FTA-ABS. ❑

THE PREMENOPAUSAL WOMAN

Thais E. Brown, MD

This covers a broad range of topics, so I left myself a lot of room to pick what I wanted to discuss. Since last time I spoke to this body it was on the postmenopausal woman, I have decided to continue to concentrate on the hormone effects on the premenopausal woman. I plan to talk on two topics: (1) Premenstrual syndrome (PMS) and (2) Anorgasmia.

Starting with the menstrual cycle and the syndrome of premenstrual symptoms that occur in many women, there are many patterns that the menstrual cycle takes. I'm not sure who picked the number of 28, but this causes a lot of women to have questions and concerns about their period not being 28 days. I have only met one or two women who have natural 28-day cycles. On birth control pills, we can produce a 28-day cycle, but 'Mother Nature' usually cannot count exactly. The menstrual cycle is a pattern of hormones in the body with feedback systems that make the female's body fertile and able to conceive if everything works properly. Because there are many things that vary this cycle, the likelihood and probability that this happens every month is rare. Several things happen during this cycle. There is Estrogen production followed by Progest-

erone production. LH and FSH are part of the feedback system to control these hormones.

The premenstrual syndrome, by definition, is a group of symptoms that occur at or following ovulation in a female cycle and are relieved with the beginning of the period. On charting these symptoms, there must be one week clear of symptoms in order for us to diagnose premenstrual syndrome. There are four categories of these symptoms that occur, and these are (1) PMS-H with physical symptoms: (2) PMS-D, depression; (3) PMS-A, anxiety; and (4) PMS-C with cravings.

Treatment of premenstrual syndrome varies from person to person and the degree of severity of the symptoms. There are many women who are not bothered or inconvenienced by these symptoms. They take them in stride and do not require any external treatments. One of the easiest treatments is Vitamin B6 and Vitamin E. Sometimes Evening Primrose Oil is added to this regimen. Occasionally, depending on the symptoms, other medicines such as diuretics or even antidepressants may be added. The serotonin mediated antidepressants seem to work very well for these symptoms. There is also hormone therapy that can be used. Progesterone Troches are the easiest to use or Progesterone intrarectal liquids which do not find favor with the patients but are written up in premenstrual syndrome lay literature.

The goal of treating premenstrual syndrome is to make the woman comfortable, tolerable, and able to function in her job and duties of everyday living.

The Anorgasmic Woman

What is anorgasmia? The purpose of this presentation is to familiarize you with this problem, help to make you more comfortable in dealing with it, and give you some ideas on how to plan treatment programs.

Orgasm is "the intense or paroxysmal emotional excitement; especially the climax of sexual excitement." Orgasmic dysfunction is a sexual disorder in which the female is unable to experience orgasm or experiences difficulty in reaching orgasm. Sixty to seventy percent of women are unable to regularly reach an orgasm.

It is easier to describe what happens when an orgasm occurs. There is a build-up of excitement, rising tension, and a sudden release. A sneeze is a comparison for this. Anorgasmia can be described as slowly climbing a high mountain, but never being able to reach the top. Sensations of warmth and tingling are preorgasmic phenomenon. Automatic vaginal contractions are the actual physiologic orgasm.

There are four steps in sexual arousal. The excitement phase, plateau phase, orgasmic phase and resolution phases comprise a cycle of sexual arousal. As people reach the age of fifty, their sexual physiology begins to change; however, they still experience the same four steps listed above.

Family medicine is a good place for anorgasmia to be dealt with. There is a special base of trust between the family physician and his patient because he has the opportunity to see patients on many occasions for a variety of problems. This enables the patient to feel safe with her family physician and not threatened.

Improper education is one of the main reasons why a woman may be anorgasmic. She may not know what an orgasm is. Techniques should be developed to fit the patient's needs and she shouldn't try to adapt to all she's read or heard. Another myth is that men are sexual authorities. This belief allows women to give up responsibility for their own sexuality. Clitoral stimulation is required for orgasm in over ninety percent of instances and this should be explained and stressed. Also, the patient should be educated about her anatomy.

Behavioral problems that may prevent orgasm include strict religious upbringing, negative emotional reactions to a partner, technical inadequacies and anxiety.

Some psychological problems that may be present are conditional acceptance of the partner, fear of loss of control, ambivalence about a commitment, and guilt.

Organic problems should also be looked for and ruled out by a good history and physical exam. Diseases that impair the lower neurological apparatus, surgical conditions, local genital disease, endocrine problems, and drugs used should be considered.

A physician's own feelings about sex should be explored so that they will not interfere with treatment.

Behavioral therapy with short-term directive sex therapy has proven to be most effective in working with anorgasmic women. Non-demanding sensate focus exercises and techniques to heighten sexual arousal are often used with secondary orgasmic dysfunction if there are no problems with the relationship of the partners. Emphasis should be placed on feelings elicited.

One approach is the program outlined in Becoming Orgasmic: A Sexual Growth Program for Women by Julia Heiman, Leslie Lo Piccolo and Joseph Lo Piccolo.

With help and guidance only 5% of the women remain anorgasmic.

If you plan to deal with this subject in your practice, explore your own feelings, do some reading, reassure your patient, and continue to offer her your support. ❑

CAROTID ENDARTERECTOMY: RESULTS OF RECENT CLINICAL TRIALS

Charles S. O'Mara, MD

During the three decades following its initial description, carotid endarterectomy (CE) was increasingly employed for treatment of atherosclerotic disease of the carotid bifurcation. Then, in the early 1980's, the usefulness of CE came under serious question. As a result, prospective trials were undertaken to address scientifically the efficacy of CE and to more clearly define indications for the operation. There are now six randomized, prospective, multi-center trials of CE with sufficient patients and follow-up to merit consideration. Three trials are for symptomatic and three are for asymptomatic carotid stenosis. Trials for symptomatic carotid stenosis include the European Carotid Surgery Trial (ECST), the North American Symptomatic Carotid Endarterectomy Trial (NASCET), and the VA Symptomatic Carotid Endarterectomy Trial. Each of these studies demonstrated clear benefit from CE for symptomatic patients with internal carotid artery (ICA) stenosis of 70-99%. For this degree of stenosis among patients in the NASCET study, the risk of ipsilateral stroke at 2 years of follow-up in medically treated patients was 26% compared to 9% in the surgical cohort ($p<0.001$), thus documenting a 65% risk reduction with surgery. For symptomatic patients with less than 30% stenosis, the study documented no benefit from surgery. Symptomatic patients with moderate (30-69%) carotid stenosis are still being studied, and no current conclusions on the efficacy of CE in this patient group can be made.

The three trials evaluating CE for asymptomatic carotid stenosis are the Carotid Artery Stenosis With Asymptomatic Narrowing Operation Versus Aspirin (CASANOVA) Study, the VA Asymptomatic Carotid Study, and the Asymptomatic Carotid Atherosclerosis Study (ACAS). In the CASANOVA study in which asymptomatic patients with 50-90% ICA stenosis were randomized between medical and surgical treatment, no difference in neurologic deficits was demonstrated between the two groups over 3 years of follow up. However, all patients with truly high-grade lesions (90-99% stenosis) underwent operation and were excluded from randomization. In the VA study, which included asymptomatic patients with 50-99% ICA stenosis, the occurrence of ipsilateral stroke over 4 years of follow-up was 9.4% in medically treated patients and 4.7% in the surgical group (p 0.06). This comparison represented a 70% risk reduction with surgery. In the NIH-funded ACAS study, by far the largest of these three asymptomatic trials (1662 patients from 37 medical centers in the U.S. and Canada), asymptomatic patients with 60-99% ICA stenosis were randomized between medical management and CE. On September 28,1994, the NIH issued a "clinical advisory" that, based on a mean follow-up of 2.7 years, statistical projections indicated a 4.8% risk of stroke in surgical patients compared to a 10.6% risk of stroke in medically managed patients at 5 years (p-0.004). These results showed a 55% risk reduction with surgery.

Information from these prospective randomized trials provides firm scientific evidence that CE is highly effective for the treatment of symptomatic patients with high-grade (70-99%) carotid stenosis. These data also give strong support for the role of CE in reducing stroke risk among asymptomatic patients with high grade lesions (60% stenosis as threshold level of consideration for CE). The role of CE for treatment of symptomatic patients with moderate (30-69%) ICA stenosis remains under investigation. In the future, further refinement of operative indications may be provided by analysis of factors other than degree of stenosis, such as plaque morphology, status of collateral cerebral circulation, incidence of CT-confirmed silent cerebral infarction, and risk factor combinations.

This information also points out the importance of achieving a low operative morbidity and mortality rate and supports previous recommendations that the combined perioperative stroke and death rate should be less than 5% for symptomatic patients undergoing CE and less than 3% for asymptomatic patients for the operation to be effective in stroke prevention. In this regard, it is important for hospitals to monitor their own operative results. Quality assurance review of CEs done during the past two years (January 1993 December 1994) at both St. Dominic-Jackson Memorial Hospital and Mississippi Baptist Medical Center reveals that 6 patients had perioperative strokes and 3 patients died after surgery among 723 CEs (symptomatic and asymptomatic patients) for a combined stroke and death rate of 1.2%.

In the future, further refinement of operative indications may be provided by analysis of factors other than degrees of stenosis, such as plaque morphology, status of collateral cerebral circulation, incidence of CT confirmed silent cerebral infarction, and risk factor combinations. ❑

EVALUATION AND MANAGEMENT OF CHRONIC SINUSITIS

William F. Sneed, MD

Sinusitis has been reported to be the most common health care complaint in the U.S. afflicting approximately 31 million persons in this country alone. Despite its being so common, sinusitis is frequently overlooked or inappropriately treated, which often leads to recurrent acute sinusitis or chronic sinusitis, and/or the development of potential life-threatening complications (e.g., intracranial or intraorbital spread of infection). To prevent these, it is important for any physician who treats patients with sinus complaints to be familiar with recent advances in our understanding of the pathogenesis of paranasal sinus disease and our ability to diagnosis the causes accurately.

Pathophysiology

The two most important defenses against infection of the sinuses are: (1) an active mucociliary system; and (2) patency of the openings (ostia) of the paired four sinuses.

The mucociliary transport system of the sinuses consists of the mucous blanket secreted by the numerous glands within the sinus mucosa and the ciliated epithelium lining the sinuses. Proper functioning of the mucociliary transport system is imperative in maintaining a normal physiologic, sterile environment of the sinuses. Viruses, bacteria, particulates, and chemicals which escape the filtering process of the nose are trapped in the mucous blanket in the sinuses, which are then propelled out of the sinus through the ostium by actively beating cilia, which beat in a predetermined direction toward the natural ostia of the sinuses.

The ostiomeatal complex is that area of the lateral nasal wall and anterior ethmoid sinus which is the common drainage pathway for the ethmoid, frontal, and maxillary sinuses. If the sinus ostia become obstructed, either mechanically or by edema of the closely approximated mucosa in the region of the ostiomeatal complex, mucociliary flow is interrupted, leading to either acute or chronic sinus disease.

Those factors that predisposed to the development of sinusitis are listed in Table 1. While systemic factors play a role in some patients, by far the more common are local factors, such as e.g., viral upper respiratory infections and allergic rhinitis, which may cause obstruction of sinus ostia secondary to mucosal swelling.

Factors Predisposing to Sinusitis

LOCAL	*SYSTEMIC*
• Upper respiratory infections	• Immune deficiency
• Allergy rhinitis	• Cystic fibrosis
• Overuse of topical decongestants	• Bronchiectasis
• Hypertrophied Adenoids	• Immotile-cilia syndrome
• Deviated nasal septum	
• Nasal polyps	
• Tumors	
• Foreign bodies	
• Swimming and diving	
• Cigarette smoke	
• Barotrauma	
• Dental extraction/injections	

TABLE I

Diagnosis

Unlike most cases of acute sinusitis, the signs and symptoms of chronic sinusitis are subtle and varied, making the diagnosis easy to miss. Establishing the diagnosis frequently requires correlation of findings from the history and physical examination (including nasal endoscopy) and radiographic findings. Plain sinus x-rays are of limited value because they tend to underestimate the presence and extent of disease in the ethmoid sinuses. Computerized tomography has evolved as the "gold standard" for more detailed and accurate assessment of the status of the sinuses. CT scan evaluation of the sinuses should be performed in those patients who do not respond to aggressive medical therapy, and not on initial presentation.

Treatment

Medical therapy should be the first line of treatment for sinusitis. The most common organisms causing sinusitis are demonstrated in Table II and, antibiotic therapy should be directed accordingly. Anaerobic bacteria and Staph. aureus play a more common role in chronic sinusitis. Antibiotics should be prescribed for a minimum of 3 to 4 weeks in chronic cases. Other aspects of medical management of sinusitis are outlined in Table III.

Patients who fail to respond to at least 4 to 6 weeks of continuous medical therapy should undergo

Medical Management of Sinusitis

- Decongestants: phenylpropanolamine, phenylephrine hydrochloride, pseudoephedrine
 - increase ostial diameter
 - enhance ciliary activity
- Topical corticosteroids: beclomethasone dipropionate, flunisolide
 - reduce inflammatory response
- Mucoevacuants: guaifenesin, potassium iodide
 - thin secretions and aid in drainage
- Antibiotics

TABLE II

Sinusitis - Organisms

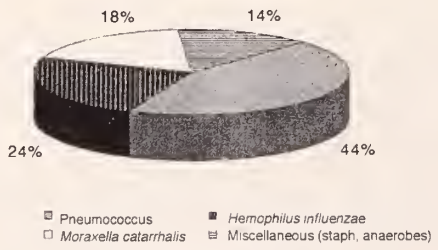


TABLE III

further surgical evaluation, including nasal endoscopy and CT examination of the sinuses.

There are two primary goals of the surgical management of chronic or recurrent sinusitis. First, correction of the underlying etiology (e.g., a mechanical blockage of the sinus ostia by nasal polyps or a deviated nasal septum); and second, restoration of ventilation and drainage of the sinuses. This second goal is usually accomplished by functional endoscopic sinus surgery, initially developed in Europe and introduced into the United States in 1985. The reestablishment of sinus ventilation and mucociliary clearance is accomplished by endoscopically removing diseased tissue from key areas and preserving the normal and functional tissue. Advantages of endoscopic sinus surgery include improved visualization; decreased blood loss, and decreased morbidity in comparison to traditional sinus surgery.

In summary, there have been fundamental changes in the diagnosis and management of sinus disease over the past decade. These changes have occurred primarily as a result of three developments: (1) our understanding and acceptance of Messerklinger's work that demonstrated that the anterior ethmoids usually are the key to persistent sinusitis; (2) the use of computerized tomography in the evaluation of sinus disease; and (3) the advent of multi-angled Endoscopes that allow excellent visualization of the nasal cavity for examination and of the sinuses during surgical procedures.❑

SOME NEWLY RECOGNIZED INFECTION SYNDROMES

William A. Causey, MD

1. Newly Recognized Viral Syndromes, or New Explanations of Old Diseases

A. Exanthem subitum, roseola, or sixth disease

This common childhood exanthem, characterized by several days of relatively high fever that dramatically lyses with the appearance of a measles-like rash, is now known to be caused by Human Herpes virus, type 6 known more commonly as HHV-6. This virus, like other members of the Herpes family of viruses (Herpes simplex virus, types I and II; Ebstein-Barr virus; varicella zoster virus; cytomegalovirus) is a double-stranded DNA virus. Its primary target cell is the B lymphocyte, and other syndromes that may be associated with this virus are a mononucleosis-like illness in older children and adults, reactivation opportunistic infections in AIDS patients, Kawasaki disease, and the chronic fatigue syndrome (very doubtful).

B. Erythema infectiosum, or fifth disease

Human parvovirus, type B-l 9, is now known to cause erythema infeciosum, a common childhood exanthem characterized by low-grade fever and a typical "slapped-cheek" facial exanthem. This illness commonly occurs in outbreaks in cycles of 5 to 7 years. In adolescents and adults, this virus causes a more prolonged viral exanthem that is often followed by a reactive arthritis that can be quite severe, mimicking acute rheumatoid arthritis. The virus infects erythroid progenitor cells, and is the principal cause of aplastic crises in persons with hemolytic anemias (especially hereditary spherocytosis and hemoglobin SS disease.) It has been associated with

fetal death when infection occurs in pregnant women, and with persistent pancytopenia in patients with AIDS.

Classic Exanthems of Childhood	
First Disease	Rubeola, or measles
Second Disease	Scarlet fever
Third Disease	Rubella, or German measles
Fourth Disease	Duke's disease*
Fifth Disease	Erythema infectiosum
Sixth Disease	Exanthem subitum, or roseola

* *Not a separate disease, but a variant of scarlet fever, or staphylococcal scarlet fever*

C. Hantavirus pulmonary syndrome

A newly recognized hantavirus was found to cause a highly fatal ARDS-like pneumonia during an outbreak in the "four corners" region of southwestern US in 1993. This illness has since been found to be fairly widely distributed in the US. The hantavirus isolated from patients during this outbreak has been found to be distinct from all known viruses in this group. Rodents are the natural host of this and other hantaviruses, and infected rodents shed the virus in their urine. Inhalation of infectious particles in environments contaminated by infected rodent urine is the principal means of human infection. Person-to-person spread of infection is known to occur. Aerosolized ribavirin may be effective in this disease.

II. Newly Recognized Bacterial Syndromes, and Some New Explanations of Old Diseases

A. Bartonellosis

Bartonellosis formerly referred to illness caused by, *B.bacilliformis,* a sandfly-borne infection manifest as Oroyo fever acutely and verruga peruana (Peruvian wart) chronically. Recently, Rochalimaea species have been reassigned to the genus *Bartonella. Bartonella (Rochalirnaea) henselae* causes cat-scratch disease in immunocompetent persons, and bacillary angiomatosis, chronic bacillemia, peliosis hepatis, and peliosis in other organs in immunocompromised (especially AIDS) patients. B. (R.) *quintana* is the agent of trench fever, a louse-borne febrile illness first recognized in allied troops in World War I. This agent has recently been found occasionally to cause chronic bacillemia in AIDS patients. Another species, B. *elizabethae,* was isolated from an immunocompetent patient with infectious endocarditis.

Afipia felis, a bacterium phylogenetically related to *Bartonella* and initially reported to cause cat scratch fever by investigators at Armed Forces Institute of Pathology, probably causes few, if any, cases of cat-scratch. Its role in human disease remains to be defined.

B. Hemolytic-uremic Syndrome (HUS)

Escherichia coli, type 0157:H7, was first isolated from patients during an outbreak of severe hemorrhagic colitis in the late-1980's. Subsequent research has proven that a significant proportion of affected individuals will go on to develop HUS. Several large and multistate outbreaks of this infection have been traced to contaminated ground beef patties used by fast food chains.

C. "Peptic" Ulcer Disease

It is now well established that several gastrointestinal syndromes formerly thought to be caused by acid-peptic attack on GI mucosa (or perhaps faulty local defense against acid-peptic attack) are in fact dependent on the presence of the peculiar bacterium, *Helicobacter pylori.* These syndromes include type II gastritis, gastric ulcer (particularly antral ulcers), and duodenal ulcers (particularly recurrent duodenal ulcer.) There is strong epidemiologic evidence to implicate H. *pylori* in the genesis of gastric carcinoma (particularly those occurring in the distal stomach) and gastric lymphoma.

D. Miscellaneous Syndromes

The etiologic agent of Whipple's disease has recently been identified by noncultural (PCR) means. There is increasing optimism that a number of inflammatory diseases of unknown cause will be explained using similar noncultural techniques. Among these are idiopathic ulcerative colitis, Crohn's disease, sarcoidosis, tropical sprue, Wegener's granulomatosis, other granulomatous diseases, rheumatoid arthritis, and systemic lupus erythematosis.❑

INTEGRATIVE CARDIOPULMONARY TESTING IN CLINICAL PRACTICE

James S. Jones, MD

Our understanding of the pathophysiology of exercise intolerance and the technology to support it has developed to the point to where physicians can stop guessing if the patient's exercise capacity is reduced and at its cause. It is noninvasive and comprehensive, assessing the functional capacity of the

heart, lungs, pulmonary circulation, and peripheral circulation simultaneously. Any cardiovascular, pulmonary, or metabolic abnormality which interferes with the patient's ability to perform exercise, also interferes with normal gas exchange of the body with the environment. Thus, in the workup of the patient with exercise intolerance measuring gas exchange at the airway can deliver more information than other forms of testing.

The integrative cardiopulmonary exercise test allows a simultaneous measurement during known exercise stress of the following parameters:

1. The balance between oxygen supply to the myocardium and myocardial oxygen requirement assessed primarily by changes indicated ischemia on EKG.
2. The adequacy of oxygen delivery (a cardiovascular function) through the muscles of locomotion.
3. The ability to transfer oxygen into and eliminate carbon dioxide from the blood (pulmonary and cardiovascular function).

To accomplish these tasks, the patient is asked to exercise at a known work rate on either a cycle ergometer or a treadmill while a number of variables are measured including:

1. EKG.
2. Blood pressure.
3. Expired air flow.
4. Oxygen uptake from the air.
5. Carbon monoxide output from the body.
6. And at times, arterial blood gasses.

All but the last can be determined "noninvasively" and a useful measure of blood oxygenation can be obtained using a noninvasive pulse oximeter during exercise.

Cardiopulmonary exercise testing seeks to answer two clinical questions:

1. Can the patient perform exercise at the level predicted for a normal person of a similar age and size?
2. If exercise capacity is abnormally low, what is the cause of this reduction?

These questions are answered by measuring such important gas exchange variables as maximum or peak oxygen uptake, C02 output, anaerobic threshold, and others. These variables, when compared to predicted values from normal subjects, answer whether exercise capacity is normal or low and if low, the pattern of gas exchange often indicates the cause or pathophysiology of reduction. The data is analyzed in both tabular and graphic form and provide answers to questions regarding the etiology of breathlessness or exercise intolerance.

Exercise testing often provides more information than pulmonary function studies or resting EKG. Spirometry at rest only estimates the patient's ventilatory capacity whereas cardiopulmonary exercise testing measures the ventilatory requirement for exercise. Although there is a relationship between FEV1 and maximal oxygen uptake, the variability of prediction limits its individual applicability. Likewise, diffusing capacity is an unreliable predictor for abnormal gas exchange. Resting EKG and systolic performance variables (such as systolic ejection fraction) may not reflect the functional impairment of a particular patient whereas direct measurement in exercise testing will demonstrate cardiac performance under stress.

Impact Of Integrative Cardiopulmonary Exercise Testing On Clinical Decision Making

Over 50% of patients that are taken to cardiopulmonary exercise testing are done so for the evaluation of unexplained dyspnea. Two-thirds of these patients are found to have their dyspnea on a cardiac or pulmonary basis. Others are found to be limited by deconditioning, obesity, and psychological factors. Cardiopulmonary exercise testing provides a way of quantitating how much cardiac or pulmonary limitation there is.

Exercise testing is used for diagnosis and screening in several clinical settings including occupational disease. Several authors have used exercise testing to screen patients with history of asbestos exposure and dyspnea. In one study of 120 asbestos workers,37% were found to have reduced exercise capacity from cardiac rather than ventilatory limitation. Cardiopulmonary exercise testing has been used to screen the patient's risk of postoperative complications. Because the increased metabolic and hemodynamic demands of surgery may be viewed as similar to the increased demands of exercise, integrative cardiopulmonary exercise testing has been suggested to improve the preoperative evaluation. Multiple studies have demonstrated that a marked increase in postoperative respiratory complications in patients undergoing thoracotomy can be predicted by patients whose maximum oxygen uptake is less than 10 to 20 ml/minute. It remains to be seen whether integrative cardiopulmonary exercise testing will play a major role in patients undergoing nonthoracic surgery or patients with nonheart or lung disease operative risks.

Exercise testing has been used in the evaluation of specific diseases such as coronary artery

disease. In patients with chronic congestive heart failure the cardiopulmonary exercise test may be useful in comparison with invasive and noninvasive assessments of ventricular function. Exercise testing may be of particular value in evaluation of the response to therapy largely because of the many important symptoms of congestive heart failure that are manifested during exercise.

Several studies have demonstrated that no estimate of cardiac function including cardiac output, echocardiographic estimated left ventricular end-diastolic dimensions, and mean velocity of left ventricular shortening correlated significantly with measured exercise capacity. Patients treated with various therapies for congestive heart failure may show no change in their resting left ventricular systolic performance variable, however, exercise performance is significantly increased. Authors have concluded that evaluation of heart failure treatment "should not focus solely on hemodynamic affects or changes in ventricular performance as a primary goal, but should include exercise testing to monitor patient progress and to judge therapeutic efficacy" (Franciosa et al. American Journal of Cardiology. 1981;47:33-9).

The role of cardiopulmonary exercise testing in a selection of patients for cardiac transplantation is evolving. Maximal oxygen uptake may become one of the standard selection criteria. The vast majority of patients have a left ventricular ejection fraction of less than 20%. However, there is poor correlation between cardiac function and exercise capability. The core question remains the optimal timing for cardiac transplantation in the failing heart and at present it appears that a maximal oxygen uptake of more than 14 ml/kglminute may safely allow the deferral of transplantation.

With regards to patients with chronic obstructive pulmonary disease (COPD), as stated earlier, spirometry does not correlate as well as might be expected with exercise tolerance because of the inability of astatic spirometry to measure the degree of ventilation perfusion mismatching and the level of pC02 that the patient maintains. Secondly, many patients with lung disease also have concomitant diseases of other organ systems that may affect exercise performance. Furthermore, spirometry does not predict the degree of oxyhemoglobin desaturation during exercise. Finally, recent studies demonstrated about 2/3 of patients with moderate to severe chronic obstructive pulmonary disease have evidence of metabolic acidosis during exercise and this finding is significant in that it suggests that oxygen delivering a predominantly cardiovascular function, may become limited during exercise in these patients. This concept is important in the treatment and rehabilitation of patients with chronic obstructive pulmonary disease. In patients with interstitial pulmonary disease, exercise testing may demonstrate oxyhemoglobin desaturation which requires supplemental oxygen. Likewise, exercise testing has been used for the evaluation of pulmonary vascular disease (nonresolving pulmonary thromboembolic disorders and pulmonary hypertension) in which a rising dead space to total volume ratio is strongly suggestive of persistent problems.

When Should Integrative Cardiopulmonary Exercise Testing Be Used?

Because of improved understanding of the physiology of exercise and the pathophysiology of exercise intolerance, guidelines for exercise testing might be considered to be as follows:

1. When the cause of dyspnea or exercise limitation is unclear.
2. To provide objective estimate of exercise capability and impairment.
3. To evaluate therapy.
4. For preoperative evaluation.

In summary, symptoms which limit exercise can usually be detected by an abnormality in the gas transport process that couple external and cellular respiration. Integrative cardiopulmonary exercise test in which gas exchanges measure dynamically rather than as a single steady state measurement can identify the pathophysiology of reduced exercise intolerance. The functional diagnosis provided by this testing can usually give sufficient information for anatomic diagnosis and if not, it usually narrows the diagnostic choices.❑

ADVANCES AND COMPLICATIONS IN LAPAROSCOPIC SURGERY

Walter R. Jones, Jr., MD

With the advent of laparoscopic cholecystectomy in 1988 by Dr. Eddie Joe Reddick in Nashville, the vistas of laparoscopic surgery were opened to general surgeons across the country. The following communication is a brief update on some of the recent advances in laparoscopic surgery as well as a review of some of the complications and precautions related to this new procedure.

The word laparoscopy originally comes from the Greek words larparo (flank) and scopein (to exam-

ine). In 1983, Karl Semm in Germany performed the first laparoscopic appendectomy reported in the literature. In 1987, Dr. Mouret in France actually performed the first laparoscopic cholecystectomy, and in 1988, Dr. Dubois in France performed a laparoscopic cholecystectomy and reported it widely. Dr. Reddick went to Europe and learned to do the procedure and came back and performed the first laparoscopic cholecystectomy in this country in 1988 working concurrently with other surgeons including Dr. William Saye in Atlanta.

Current laparoscopic procedures available are extensive and the following will review some of the diagnostic and therapeutic indications.

1. Diagnosis of abdominal pain. The laparoscope when used as a tool for diagnosis of abdominal pain has been reported by several authorities to have an 80% to 90% level of accuracy. This certainly depends on patient selection and sampling. The following statement may well be considered carefully prior to undertaking laparoscopy in all patients. "Enthusiasm of the news media, the public, and some surgeons for laparoscopic procedures has often overshadowed their lack of documentation and their purported advantages."

2. Staging malignant tumors.

3. Abdominal trauma. Diagnostic accuracy reported in 90% level.

4. Laparoscopic cholecystectomy

During the year 1993, 85% of cholecystectomies in the United States were done laparoscopically. The reported mortality was less than 1% for the procedure in 1993. Injuries sustained at the time of laparoscopy were injuries to the common bile duct, the bowel and to vascular structures. The reported incident of common duct injury was less than one-half of 1% but was reported to be as high as 2.2% in the first thirteen cases of a given surgeons' experience with laparoscopic cholecystectomy. On a more somber note, the injury was reported to be 7 to 8 times more common with laparoscopic cholecystectomy than conventional open cholecystectomy in data reviewed from the New York State Health Department and certain insurance adjustors.

5. Laparoscopic appendectomy. This was first performed in 1983 by Dr. Karl Semm. Laparoscopic appendectomy remains a relatively easy procedure to perform except in cases of retrocecal appendicitis. The present questions regarding laparoscopic appendectomy: is it cost effective? and does it actually save time and shorten hospital stay? These questions are unanswered at the present time.

6. Common bile duct exploration. The status of common bile duct exploration at the time of laparoscopic cholecystectomy via the laparoscope remains a controversial issue. Certainly, this can be done in the experienced hands. New instrumentation is being developed daily to facilitate this. It has been reported that up to 15% of patients undergoing cholecystectomy have common bile duct stones. The controversy rages as to whether preoperative ERCP for extraction of common duct stones is preferable to actual laparoscopic removal of the common duct stones.

7. Inguinal hernia repair. Laparoscopic hernia repair is another procedure which is gaining in popularity. The obvious reported advantages are decreased hospital stay and rapid return to work. Approximately 600,000 hernia repairs are done in the United States each year. In two large series of laparoscopic hernia repairs, totaling 1,443 patients, a 2% recurrence was reported as compared to the normal 2 to 5% recurrence rate with conventional open herniorrhaphy. A reported cost of laparoscopic hernia repair was approximately 135 to 150% that of conventional open hernia repair. One disadvantage is that a general anesthetic is required for laparoscopic hernia repair as opposed to many conventional open herniorrhaphies being done under local anesthesia or subarachnoid block.

8. Laparoscopic colon resection. A laparoscopic colon resection predominately is done as a laparoscopic assisted colon resection. The necessity for making an abdominal incision to remove the specimen is needed in the vast majority of cases. Occasional reports of removal of the sigmoid colon endoluminally with transanal extraction of the specimen at time of laparoscopy have appeared in the literature, but this usually not an option. Problems that have been cited with a laparoscopic colon resection are as follows:

Extended length of the procedure as well as increased cost from instrumentation and increased operating time. Another major issue is that of adequate surgical margins in tumor patients as well as adequate lymph node sampling. A more disturbing factor regarding removal of malignant lesions via the laparoscope has been the issue of metastatic implants in the laparoscopic trocar sites. There have now been 20 reported cases in the literature of metastatic implants of tumor in the laparoscopic trocar sites, and in at least two of these cases, the patient had a Duke A colon cancer which should theoretically have a very low recurrence rate by conventional surgical extirpation.

9. Hiatal hernia repair or GERD surgery. Hiatal hernia repair has become a rapidly growing aspect

of laparoscopic surgery and indications for repair of hiatal hernia have been relaxed with the advent of this new procedure. Traditional Nissen fundoplication can be done very successfully via the laparoscope with the appropriate learning curve. A lesser procedure, the Toupet procedure, a half wrap of the fundus of the stomach has been reported to be less advantageous. Reported advantages of the laparoscopic hiatal hernia repair have been decreased hospital stay with excellent results ap proaching the 90 to 95% range.

10. Peptic ulcer surgery. Peptic ulcer surgery has been performed through the laparoscope, and the two primary procedures that have been done to date have been highly selective vagotomy and Graham closure of a perforated ulcer. Pyloroplasty has been done and an occasional gastrectomy has been done, but these have not gained great acceptance to date.

11. Other laparoscopic procedures. This represents a partial list of other procedures which have been reported in literature: Nephrectomy, Heller-esophagomyotomy, adrenalectomy, gastrojejunostomy, cholecystojejunostomy, splenectomy, splenic salvage procedure, and Whipple procedure.

All of these procedures can be done laparoscopically, some with great requirements of time and instrumentation and possible complication. Future analysis and case trials will decide the efficacy of these procedures.

Complications in Laparoscopic Surgery

The following represents a review of some of the complications listed in the New England Journal of Medicine in the article published in February, 1994 by Soper. A series of 77,664 laparoscopic cholecystectomies was reviewed. The reported mortality rate was 0.5%, and 33 deaths were reported with 18 of the 33 deaths (54%) due to technical complications. Morbidity reports an incidence of 2 to 6% of common bile duct injury, bile leaks, infection, retained common duct stones and hemorrhage.

Major vascular injuries were reported in 36 cases (.05%) resulting in the death of two patients. Other complications were related to inadvertent trocar placement, intestinal injury, hernias occurring in the trocar cannula site, metastatic trocar implants and wound infections in the trocar sites.

An additional area which has been looked at is the complications of pneumoperitoneum. The complications of pneumoperitoneum are related to several factors. One obvious factor is the increased pressure in the abdomen resulting in decreased venous return and decreased cardiac output. Gas embolism has also been reported from inadvertent placement of the trocar in a vein. In addition, the rapid absorption of C02 by patients who are C02 retainers has resulted in hypercarbia and acidosis, occasionally resulting in death.

Additional problems with the carbon dioxide pneumoperitoneum have been noted in patients with sickle cell disease where C02 absorption and resulting acidosis may precipitate a sickle cell crisis. In addition, when cardiac arrhythmias were assessed in a series of patients with C02 pneumoperitoneum, an incidence of 17 of nonfatal cardiac arrhythmias were reported. Additional complications of pneumoperitoneum reported are pneumothorax and pneumomediastinum.

With the complication related to carbon dioxide pneumoperitoneum, the advent of gasless laparoscopy has been explored. Certainly, this would avoid the hypercarbia and acidosis in predisposed patients as well as difficulty with the pressure phenomena and decreased cardiac output. The patients that seemingly would benefit from gasless laparoscopy would be children, the pregnant patient, the trauma patient with a ruptured diaphragm, hypovolemic patients and a patient with venous injury. The difficulty with maintaining adequate visualization during gasless laparoscopy is obvious. A series of external suspension retractors have been postulated, but their use has not gained wide acceptance at the present time.

In summary, laparoscopy represents a stimulating and exciting new field of endeavor for the surgeon. To this date, the obvious benefits of laparoscopic cholecystectomy cannot be argued with its widespread acceptance and excellent result. Certainly, the continued efforts in this field and careful analysis of the data will be required to sort out the indications and appropriate use of this new modality. ❑

Medical Malpractice and Doctor-Patient Communication

Poor physician-patient communication more than poor quality of care or medical negligence usually motivates patients to initiate a malpractice suit against their physician, according to Wendy Levinson, M.D., of Oregon Health Sciences University and Good Samaritan Hospital, whose research is supported by the Agency for Health Care Policy and Research. In a recent editorial in the November 1994 issue of the Journal of the American Medical Association, she points out that many malpractice claims are initiated when no lapse in quality of care has occurred and even when there is no evidence of medical injury. Conversely, there are many true injuries to patients that occur because of medical negligence for which patients do not seek compensation.

About 1 percent of hospitalized patients suffer a significant injury due to negligence, yet less than 3 percent of these injured patients or their families initiate a malpractice claim. Two studies, summarized below, appear in the same journal issue and support Dr. Levinson's view that doctors are usually sued because of patient dissatisfaction with the physician rather than poor quality of care.

Entman, SS, Glass, CA, Hickson, GB et al. (1994, November). The relationship between malpractice claims history and subsequent obstetric care." (AHCPR grant HSO6499). *JAMA* 272(20), pp 1588-1591.

In this study, Dr. Entman and colleagues examined the relationship between the malpractice claims history of Florida obstetricians between 1977 and 1983 and the quality of clinical care they were providing to patients 5 to 10 years after the claims. The physicians were classified into one of four groups, based on their claims history: high frequency, high pay (frequent claims and high payments), no claims, and all others. The researchers found no differences in the quality of clinical care, regardless of obstetricians' malpractice history. The rate of cesarean delivery; inappropriate, unindicated, or excessive testing; and adverse outcomes such as fetal or infants deaths, were similar for all four physician groups. The authors conclude that attempts to identify physicians at risk for future clinical errors by using data on prior malpractice claims may be misguided. This study shows no increased likelihood that substandard clinical care would be provided by physicians with prior claims.

Hickson, GB, Clayton, EW, Entman, SS, et al. (1994, November). "Obstetricians' prior malpractice experience and patients' satisfaction with care." (AHCPR grant HS06499). *JAMA* 272(20), pp 1583-1587.

The second study by the same group of researchers shows that physicians who have been sued fre-

quently are more often the objects of interpersonal complaints, even by their patients who do not sue. The investigators interviewed nearly 1,000 mothers of all stillborn infants, infants who had died, and a random sample of mothers of viable infants from 1987 Florida vital statistics records to assess their satisfaction with their obstetric care. Patients whose physicians had frequent prior malpractice claims were significantly more likely to complain that they felt rushed, never received explanations for tests, and were ignored, even during labor and delivery. Women of physicians who had never been sued were most satisfied with their obstetric care. The authors conclude that patients are more likely to sue their physician if they feel that the physician didn't care or didn't inform them adequately. They recommend that physicians improve their communication skills.❑



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D. Stanley Hartness, Jr., MD

The President's Page

Born To Serve

"... I just learned that I passed the Connecticut State Bar examination and I'm tickled pink. I think the last time I was so excited was when Pepsi started dating its cans for freshness...the only thing in life more tiresome than the potential practice of law is the actual study of law...After reviewing all the evidence, I arrived at the hideous truth: Like most saps who enroll in law school, I just had nothing better to do."

These insightful comments by a law school graduate in a "first-person" Honolulu Advertiser article caught my eye during the AMA Interim meeting last December.

Recognizing that surely not all members of the legal profession share that writer's opinion (and with profound apologies to my attorney son-in-law), I invite you to contrast the above ruminations with this exchange from Ferrol Sams' When All the World Was Young when protagonist Porter Osborne questions whether he wants to re-enter medical school following World War II:

"Why? Why do you want to be a doctor?"

"Osborne, get this straight. There are two kinds of people in the world: those who give to other people and those who spend all their lives taking. Or planning to take...I'm not a taker, Osborne, I'm a giver. Some folks were born to serve and others to be looked after. I'm Will Barton. I was born to give and to serve, and the world had well better know it and get ready. There's no better place to do it than in medicine. I'm going to be a doctor."

Recognize yourself...hopefully? Medicine indeed continues to afford unique opportunities tempered by sobering responsibilities for us as physicians to serve both our patients as well as our profession.

Despite the distaste of current medical issues such as drug abuse, violence, sexually transmitted diseases, and teen pregnancies, the focus of our profession must

(continued on page 144)

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
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MAY 1995

Swimming In A Pool of Paper

Now and then things come along to shake the foundations of the cardhouses of our careers and livelihoods. I felt such a tremor in November on receiving the monthly issue of the Medicare News. The entire issue was devoted to documentation guidelines for the various levels of evaluation and management charges, guidelines that will be used to determine whether or not we have overbilled Medicare for a particular complexity of office visit. It is tough reading. Maybe a better term is overwhelming, for my initial response was a sigh of hopelessness, followed by some changes in my notes and then to not pick up the guidelines again until writing this article. I see now how inadequate my changes were despite the effort put into them.

An example is in order. According to the guidelines a history consists of eight elements, things such as, and I quote, location, quality, context, modifying factors and associated symptoms. A "brief" HPI deals with up to any three elements. An "extended" HPI discusses four or more. Another. Of the three areas—past, family and social histories—to be "complete" for an established patient requires addressing two. But we must remember to address all three for a new patient, or we are not "complete." Things unravel quickly in the decision making section, so that after a series of guidelines the statement is made that "the determination of risk is complex and not readily quantifiable." Yet a determination is necessary to decide decision making complexity, one of the three elements that decide the visit level.

Oh well, nothing but time on our hands. But the problem is we could write endlessly and never satisfy these guidelines, particularly if our notes are to be reviewed by non-physicians who have no clear concept of a clinical encounter. What you and I consider as addressing a point may go completely by an unaware reviewer.

Medicine is not a bureaucratic profession. We do not think bureaucratically. An effort to make us document an office visit to please someone with a long, exacting checklist is doomed to failure. Simply too many sick people crowd our waiting rooms to think otherwise. I am informed that HCFA's efforts will be, at least initially, educational. Yet the essence of the government is force; the IRS doesn't merely suggest that citizens pay their taxes. The effect of the guidelines is to leave us all open to ruinous reviews of our records with potentially catastrophic financial results.

(continued on page 144)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(President's Page continued from page 142)

sexually transmitted diseases, and teen pregnancies, the focus of our profession must remain one of patient advocacy, lest we be perceived as arrogant. Despite the excesses of government regulations, third-party interference, and managed care scenarios, the voice of organized medicine must remain one of unity, lest we be perceived as speechless.

Mal has passed the torch of our Association to me, and the flame has continued to leap high while in his custody. And as the torch passes through your component society this year, may you not only reflect the light of humanitarianism and healing—the hallmarks of our profession—but may you also fuel the fire so that we may wrest control of our health care system.

My prayer is that I will be renewed, enlightened, and challenged to serve as a credible, creative, and communicative ambassador for our state medical association. With God's help and guidance and with your participation and support, we will enjoy a successful and productive year.

Stanley

(Editorial continued from page 143)

The situation calls for a measure of restraint on HCFA's part. Only the most egregious abusers of the system should face sanctions, and those doctors who are making even unexacting efforts to comply should not have to face them. Any other approach should call for the scrapping of the tiered levels of evaluation and management codes, perhaps in favor of some single payment for any length or complexity of visit. Bad as such a prospective payment system would be, at least we could keep our minds on the patients instead of on the page.

Leslie E. England, MD
Associate Editor

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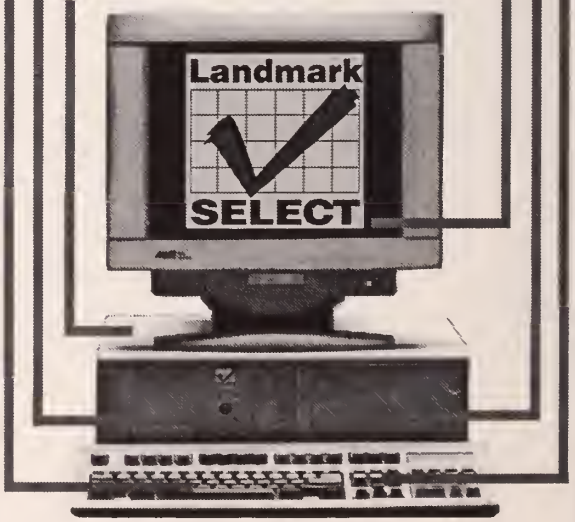
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Letters

Myron W. Lockey, MD, Editor
Journal of the Mississippi State Medical Association

Your article in the March, 1995, issue of the Journal of the Mississippi State Medical Association on **Laryngeal Carcinoma - A Relationship To Tobacco and Alcohol Use** was informative and timely. The Mississippi State Department of Health has been actively working to persuade physicians and dentists to consistently counsel patients about the health effects of tobacco use.

I have visited schools in Mississippi and talked to first grade students who smoke. Those young smokers are knowledgeable about brands, tastes, and costs but not about the risks to their health. It's heart-breaking to watch a six or seven year old child reach into his shirt pocket and produce a pack of cigarettes and brag that he is saving wrappers for a "Camel cup." It's frightening to listen to first grade teachers talk about the number of students who arrive at school smoking each morning. At a meeting of the Mississippi Tobacco-Free 2000 Coalition in April, 1994, a dentist from Jackson stated that he has treated four year old patients who chew tobacco. That, too, is disturbing.

The tobacco industry declares that it does not target youth and does not condone youth smoking, but the facts prove differently. Twenty-eight percent of Mississippi youth in grades 9 - 12 are current smokers and 24% of high school males chew tobacco according to the 1993 Youth Risk Behavior Survey. These figures are staggering. Much needs to be done and I believe your call to action in this article will inspire other physicians to begin to do the "macho" thing by becoming involved and trying to curb tobacco use.

The Mississippi Tobacco-Free 2000 Coalition was formed in 1993, and serves as a vehicle to educate the public and raise awareness regarding the tobacco-related disease and death epidemic in this state and nation. The mission of this coalition is to "create a tobacco free Mississippi." Recognizing that it will take grass roots activities to realize this mission, coalition members are actively writing a tobacco control and prevention plan for Mississippi.

The next meeting of the coalition will be held at 1:00 p.m. on May 11 and will be held at the Career Development Center on Ellis Avenue. Please consider this an invitation for readers of the Journal of the Mississippi State Medical Association to attend this meeting and join the coalition.

Cheryl Grubbs
Tobacco Prevention Program
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Foundation Presents Quality Forum

The "new" focus of the Foundation for Medical Care as the state's federally designated Peer Review Organization is becoming simply "the focus." With the Health Care Quality Improvement Program going into its third year, it was quite obvious at a recent presentation in Jackson that the new approach has come into its own. The former intense scrutiny of medical records or individual case review is being dramatically decreased and is now giving way to analysis of health care data to determine patterns of health care delivery in hospitals throughout the state.

The Foundation's second annual quality forum, entitled "Moving Toward Quality Improvement," attracted some 100 people from throughout the state. (The first forum was September 1994's "Quest for Quality" which defined the program and its plans, ambitions and possibilities.) On March 30, physicians and providers joined Foundation staff for the second event to discuss various aspects of quality, including specific study projects now underway. Featured speakers came from the Health Care Financing Administration (HCFA) regional office in Dallas; the Alabama Quality Assurance Foundation in Birmingham; and the University of Mississippi Department of Medicine, Also, three Mississippi hospital representatives shared results of quality improvement projects.

David Simpton, who has served as chief of the HCFA Regional Office Quality Improvement Programs since March 1994, and Jim Nolen, HCFA project officer for the Foundation, traveled from Dallas for the forum. Mr. Simpton discussed HCFA's strategic plan for quality improvement.

Dr. Jim DeLong, assistant clinical coordinator for the Alabama Quality Assurance Foundation, presented an overview of the national cooperative cardiovascular project (CCP). He was accompanied by Rhonda Wallace, RN, AQAF's project director for CCP. They later met with our staff who discussed plans and details for its current CCP work.

Dr. John B. O'Connell, chairman of the UMC Department of Medicine, and study group chairman of the Foundation's heart failure project, discussed heart failure and its treatment, showing the importance and direction of this Foundation project.

The hospital presentations were billed as "candid discussions about improvement programs," and the presenters lived up to the promotion. Discussing their improvement programs were:

Barbara Ainsworth, nursing quality nurse reviewer from Nursing Administration, Mississippi Baptist Medical Center, who presented that facility's influenza project.

Georgia Millender, director of Quality Review Services at Baptist Memorial-Golden Triangle in Columbus, who talked about the stroke project; and

LaVerne McDaniel, infection control practitioner of Field Memorial Hospital in Centreville. She discussed the influenza program,

Their honest, enthusiastic overviews of assessment, data gathering and participation in the projects were encouraging for the Health Care Quality Improvement Program efforts.

Closing out the program were the Foundation's clinical coordinators, Dr. Alton Cobb and Dr. Candace Keller, who updated the participants on current projects.

A video tape recorded the presentations and is available for buying or borrowing. Call the Outreach Department and arrange to view it if you are interested.

James S. McIlwain, Jr., MD, Foundation Medical Director □

MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Benefits

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE
The MSMA provides a toll free WATS for any member to call to inquire about medical matters and programs of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

MEDICAL OFFICE SUPPLIES
MSMA members can save up to 40 percent on medical office supplies through "AMA Purchase Link". Under this program discounted medical, surgical and pharmaceutical products are available from Henry Schein, Inc., the largest nationwide distributor of such products to physicians' offices.

THIRD PARTY PAYOR LIAISON
MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE
MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

WORKERS' COMPENSATION INSURANCE
The MS Physicians Insurance Company (MPIC) is affiliated with MSMA and currently provides workers' compensation coverage to physicians' offices at the lowest rates available. MS law requires every employer with five or more employees to obtain such insurance. For further information contact Jennifer Corson at MPIC.

PRACTICE MANAGEMENT
Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

DEBT COLLECTION SERVICE
Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call MSMA.

INSURANCE/FINANCIAL/RETIREMENT PROGRAM
MSMA members have available several insurance plans designed exclusively for physicians. Through the "group" buying power of the association the plans can usually be obtained at lower cost and there is the advantage of "one stop" coverage. For further information contact Executive Planning Group.

MEDICAL MALPRACTICE INSURANCE
The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. The Company currently has 2000 policy holders. Extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-354-5433 or 800-898-0251 (In-State-WATS).

AMA Purchase Link - 800-772-4346.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company - P.O. Box 5229, Jackson, MS 39296-5229, 601-354-5433 or 800-898-0251 (In-State-WATS).

Medical Assurance Company of Mississippi - P.O. Box 4915, Jackson, MS 39296-4915, 601-353-2000 or 800-325-4172 (In -State-WATS).

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MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Services

When you need information on a specific subject or association service, the following MSMA staff person(s) are available to assist you.

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Medical Society Presents 1995 Achievement Awards

The Singing River Medical Society established the **Singing River Medical Society Award of Achievement in 1991** to recognize and award excellence in language/communication skills (based on English ACT scores) as demonstrated by a graduating senior at each of the 7 high schools in Jackson County. Since that date, $5250 have been awarded. The 1995 recipients are as follows:

John Gordon Brooks - Pascagoula High School - son of Mr. & Mrs. Charles Brooks - English ACT of 36 - plans to attend the University of Alabama at Birmingham to study computer engineering.

Kathleen D. Savage - Ocean Springs High School - daughter of Ms. Martha Savage - English ACT of 34 - plans to enter the pre-med program at Belhaven College or the University of Mississippi.

Monique Elizabeth Curet - Resurrection Catholic High School - daughter of Mr. & Mrs. Charles Curet - English ACT of 34 - plans to major in journalism at Spring Hill College, Tulane University, or the Universities of Alabama or South Alabama.

Maxie Sikora - Vancleave High School - daughter of Wayne and Jane Sikora English ACT of 33 - plans to major in biomedical science at the University of South Alabama.

Christopher Shane Presley - Moss Point High School - son of Fred and Maude Presley - English ACT of 32 - plans to attend Mississippi State University and study engineering.

Gary Barton - St. Martin High School - son of Gary and Vickie Barton English ACT of 31 - plans to attend the University of South Alabama.

Robert Lee Horton - East Central High School - son of Charles and Penny Horton - English ACT of 29 - plans to attend Mississippi State University and study computer programming.

Steve Demetropoulos, M.D., serves as president and Hal Moore, M.D., serves as secretary/treasurer of Singing River Medical Society which is composed of 92 Jackson County physicians.



President to President

While AMA President, Dr. Robert E. McAfee, second from left, was in Jackson speaking to the Rotary Club on Domestic Violence, he took time out to visit in the State Medical offices with MSMA President Dr. Mal Morgan, second from right, Dr. Sidney Graves, left, and Dr. Vann Craig, right.

Review A Book

The following book has been received by the Journal MSMA. Members of the MSMA interested in reviewing this book should contact the Managing Editor, Journal MSMA. After submitting a review for publication, you may keep the book for your personal library.

Vandals at the Gates of Medicine — Historic Perspectives on the Battle over Health Care Reform. **Miguel A. Faria, Jr., M.D., Hacienda Publishing, Inc., Macon, Georgia, $41.95, 1995.**

About the author: Dr. Faria is Clinical Professor of Surgery (Neurosurgery) and Adjunct Professor of Medical History at Mercer University School of Medicine in Macon, Georgia. Dr. Faria has published over 60 articles ranging from scientific research papers on medicine and neurosurgery to essays on medical history and op-ed pieces on socio-economic and political issues affecting American society in general and health care in particular.

In addition to his responsibilities at Mercer, Dr. Faria is also the editor of the Journal of the Medical Association of Georgia and is active in health system reform at both the state and national levels. ❑

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Med Students Get Match Results

University of Mississippi Medical Center (UMC) senior medical students received their match results on Wednesday, March 15, at Match Day ceremonies as 250 of their classmates. relatives and friends watched. Match results are released at exactly the same time to senior medical students across the country. Of the 93 UMC senior medical students, 90 participated in the National Resident Matching Program (NRMP). Sixty-five NRMP participants, or 72 percent, got either their first or second choice, according to Dr. Helen R. Turner. associate dean for academic affairs.

Twenty different specialty areas, from anesthesiology to urology, were chosen by UMC students. Fifty-two of the 93 students will train in primary care specialties. Twenty-one will train in internal medicine, 12 in family medicine, 11 in pediatrics, seven in ob-gyn, and 1 in med-peds.

Thirty-nine students will take residency training at UMC, beginning July 1. The other 54 senior students will pursue residency training in institutions in 15 other states.

"This was a very successful match for our students," Dr. Turner said. "The match results are the culmination of four years of hard work toward this goal and Match Day is certainly one of the highlights of the students' senior year.

The NRMP began about 40 years ago with the aim of providing a uniform process and date for decision making for applicants and residency programs. As a result of the process. senior medical students and residency programs throughout the country receive their results at exactly the same time on Match Day. ❑

Drs. Morrison and Parent named Department Chairman

Two new School of Medicine department heads have been appointed at the University of Mississippi Medical Center.

Dr. John C. Morrison has been named chair of the Department of Obstetrics and Gynecology, and Dr. Andrew D. Parent is new chair of the Department of Neurosurgery.

Dr. A. Wallace Conerly, vice chancellor for health affairs and dean of the School of Medicine, announced the appointments following approval by the Board of Trustees at their April 20 meeting.

"Dr. Morrison and Dr. Parent have proven themselves to be prolific scholars, superb physicians and excellent administrators," Dr. Conerly said. "They have the kind of experience these two vital departments require.

A member of the UMC faculty since 1979, Dr. Morrison was on the ob-gyn faculty at the University of Tennessee Center for Health Sciences for seven years before coming to UMC. He is chief of staff for University Hospitals and Clinics at the Medical Center.

His research, establishing Dr. Morrison as a national and international authority, has made fundamental changes in the way physicians treat sickle cell anemia during pregnancy and has been instrumental in developing treatment methods to prevent premature delivery.

Dr. Morrison received the BS degree from Memphis State University in 1965 and earned the MD degree in 1968 at UT for the Health Sciences. He took his internship at the City of Memphis Hospital and completed his residency at UT, Center of Memphis Hospital in 1972.

In 1991, Dr. Morrison received the AMA's William Beaumont Award for outstanding contributions to medical education, medical research, or clinical practice.

He is the author of 265 peer reviewed articles, 84 chapters in textbooks, and three books. Dr. Morrison—whose appointment is effective July 1—succeeds Dr. Winfred L. Wiser who is stepping down from the chair but will remain on the faculty.

Before joining the Medical Center faculty in 1978 as assistant professor of neurosurgery, Dr. Parent was a captain and general medical officer in the U.S. Air Force.

He received the AB degree from St. Michael's College in Winoski, Vermont, and earned the MD at the University of Vermont College of Medicine. Dr. Parent took internship at the University of Texas Medical Branch in Galveston and completed residency in neurosurgery at Emory University. He completed a research fellowship in neurosurgery at the University of Texas Medical Branch in 1971.

Dr. Parent was appointed associate professor of neurosurgery in 1982, and professor in 1988. He has also served as chief of staff and vice chief of staff for University Hospitals and Clinics at the Medical Center.

He has authored or co-authored more than 89 publications including journal articles, abstracts, book chapters and editorial reviews. His research primarily focuses on pituitary pathology.

Dr. Parent currently serves as editorial reviewer for Pediatric Neurosurgery, the official journal of the Society of Pediatric Neurosurgery and *Neurosurgery*, the official journal of the Congress of Neurological Surgeons.

He has served as interim chair since the retirement of Dr. Robert Smith in 1994. His new appointment was effective April 20. ❑

Calcium Chanel Blockers Safe, Says UMC Hypertension Expert

An expert in high blood pressure at the University of Mississippi Medical Center (UMC) says he will continue prescribing calcium channel blockers to appropriate patients in spite of a recent report which suggested that the class of drugs might be associated with a higher risk of heart attack.

Dr. Dan Jones, associate professor of medicine and director of the department's hypertension division, says the report, given March 10 at a meeting of the American Heart Association, was "observational" in nature.

"Of the five types of drugs used to treat hypertension, calcium channel blockers are the most expensive," Jones said. "Most physicians don't prescribe them for mild cases of hypertension, or in cases where other, less expensive, drugs work just as well." "In other words, the patients taking calcium channel blockers were probably at higher risk from the beginning."

While not necessarily flawed, the study, he said, presented only preliminary data.

Such studies based only on observation are intended to give clues about the direction other studies should take, he said. All five classes of anti-hypertensives have been clinically tested for effectiveness and safety. Drugs in two classes—diuretics and beta blockers—have been tested in randomly selected patient populations and do reduce the rate of heart attack.

The newer classes of blood pressure-reducing drugs—calcium channel blockers, ACE inhibitors and alpha blockers—are effective in reducing blood pressure, but large clinical trials comparing the effectiveness of each against the other in heart attack prevention have yet to be done.

"Such a study is now underway," Jones said, "with 42,000 patients across the country participating."

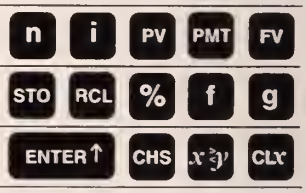
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Personals

Gene R. Barrett of Mississippi Sports Medicine, Jackson, presented a study at the Southeastern Conference Sports Medicine Symposium in Atlanta, Georgia during the Southeastern Conference Tournament. The paper was on results of anterior cruciate ligament surgery.

Andy Broussard of Gulfport has been named chief of staff elect at Gulf Coast Medical Center for 1995-96.

C. Ralph Daniel, III, of Jackson, recently gave talks on nail disorders at Vanderbilt University and in Dallas, Texas.

William B. Geissler, of UMC Jackson recently had two poster exhibits on Sports Medicine injuries at the American Academy of Orthopaedic Surgeons annual meeting in Orlando, Florida. One poster was on *Arthroscopic Management of Anterior Cruciate Ligament Tibia Avulsion Injuries* and a second poster on *Snapping of the Hip Secondary to Iliotibial Tract.* In addition, Dr. Geissler was invited to speak at the American Society for Surgery of the Hand Specialty Day, on the topic "Arthroscopic Management of Distal Radius Fractures."

Louis Harkey, assistant professor of neurosurgery at UMC was elected secretary of the medical staff for 1995-96.

John F. Hassell with Laurel Family Clinic has been recertified as a Diplomate of the American Board of Family Practice (ABFP).

William Henry of Biloxi has been named secretary-treasurer of the medical staff at Gulf Coast Medical Center for 1995-96.

Randall D. Hicks has associated with Gary Davis and Bill Moore at Jackson Nephrology Associates, 3120 Old Canton Road for the practice of Nephrology.

Connie McCaa professor of Ophthalmology at UMC has been named vice chief-of-medical staff for 1995-96.

John C. Morrison of Jackson has been named chair of the UMC Department of Obstetrics and Gynecology.

Andrew D. Parent of Jackson has been named chair of the UMC Department of Neurosurgery.

David Sawyer of Gulfport, medical director of emergency services, has been named chief of staff at Gulf Coast Medical Center for 1995-96.

Carol Scott-Conner, professor of surgery at UMC has been named Chief of Medical Staff for 1995-96.

Michael Shrock announces his association with Todd Willis in Philadelphia Family Practice, for the practice of Family Medicine, 1120 East Main Street, Philadelphia, MS.

E. Frazier Ward, associate professor of Orthopaedic Surgery at UMC, served as Visiting Professor and Guest Lecturer during Grand Rounds at Fitzsimons Army Medical Center and the University of Colorado Health Sciences Center in Denver, Colorado, March 14-15. Dr. Ward was also the guest speaker at a meeting in Bochum, Germany, on March 30. He presented *The University of Mississippi Medical Center's Experience with the Unreamed Humeral Nail* to a group of surgeons from Europe, Australia, and the USA.

Wallace W. Weatherly announces the relocation of his practice of Orthopaedic Surgery and Sports Medicine to Mississippi Baptist Medical Center, Medical Arts Building West, 1151 North State Street, Suite 404, Jackson. ❑

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

Physicians' Recognition Award



Six MSMA members were named recipients of the AMA Physicians Recognition Award in March 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

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Shanti Pandey, MD

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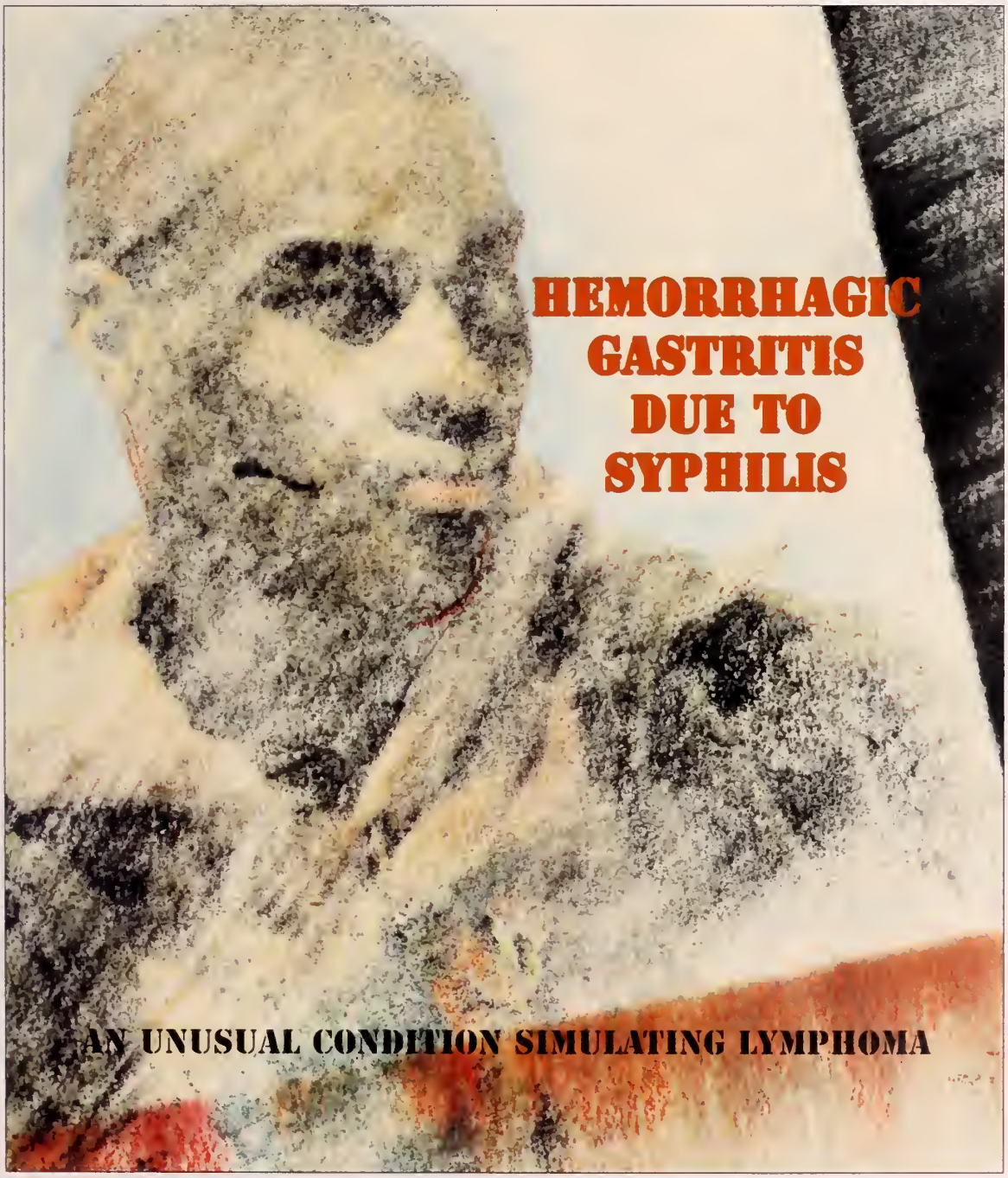
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Hemorrhagic Gastritis Due to Syphilis
An Unusual Condition Simulating Lymphoma

William J. Wetzel, M.D.
Margaret Tharp, M.T.
Billy Long, M.D.
James Johnston, III, M.D.
Cynthia Hayden-Wright, M.D.

Syphilis is widespread in Mississippi with an incidence six times the national average. In one county, the incidence is thirty-six times the expected national rate.[5] With the widespread abandonment of routine serologic testing on hospital admission it is possible that this protean disease is being missed. We describe a patient with hemorrhagic gastritis due to secondary syphilis. This presentation is infrequently documented in the literature and scarcely mentioned in standard textbooks.[1,2] The clinical course and endoscopic appearance are dramatic and physicians, especially gastroenterologists and pathologists, should be alert to this entity.

CASE REPORT

A 29-year-old black male from Yazoo City presented with worsening abdominal pain for six months. He had been vomiting for two weeks and in the three days before admission developed hematemesis and melena. Endoscopy showed greatly thickened gastric folds with mass effect as well as erosion and ulceration with bleeding (Figure 1). The impres-

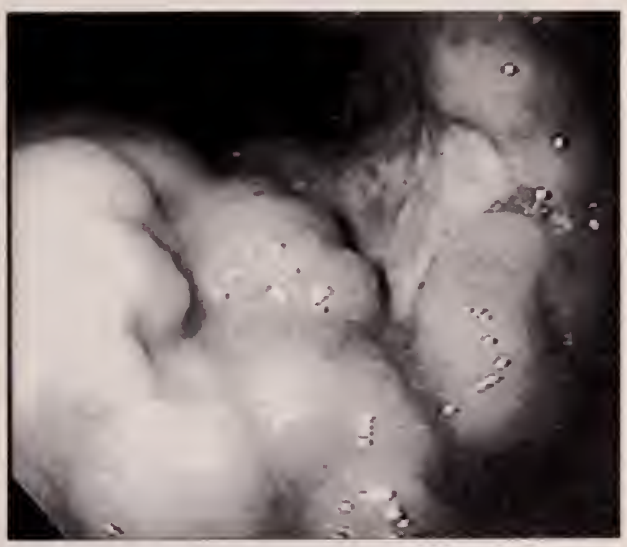


Figure 1. Endoscopic appearance large nodular folds simulate tumor.

sion was strongly in favor of lymphoma, however, microscopic examination of the biopsy fragments showed a reactive inflammatory appearance. Because of the admixture of plasma cells a request was made

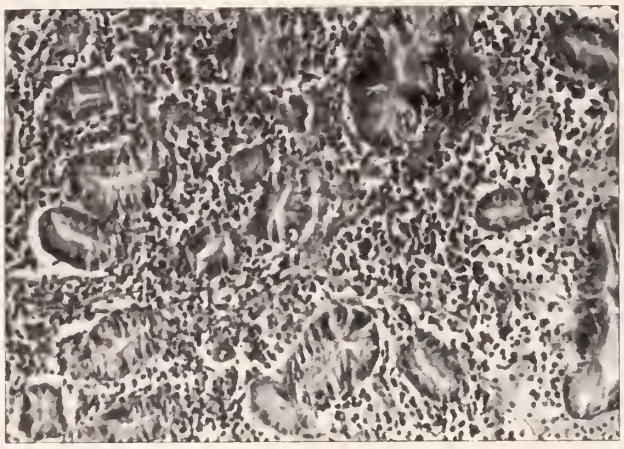


Figure 2. Stomach biopsy Nonspecific inflammatory infiltrate featuring lymphocytes and plasma cells (H and E x 200).

for serologic testing for syphilis (Figure 2). Repeated silver stains failed to reveal spirochetes. Because of the strong clinical impression of lymphoma, additional biopsies were soon obtained. This time silver stains (Steiner modification of Warthin-Starry) showed numerous spirochetes in the lamina propria (Figure 3). VDRL was positive at a dilution of 1:64 and this was confirmed by the demonstration of fluorescent treponemal antibodies (FTA-ABS). Physical examination showed a penile condyloma, generalized lymphadenopathy and a hyperkeratotic rash involving the soles of the feet. Treatment with intramuscular penicillin resulted in improvement of his abdominal complaints.

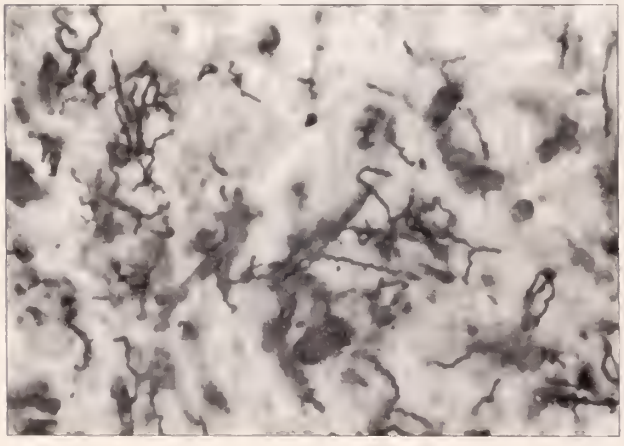


Figure 3. Spirochetes invading lamina propria diagnostic of syphilis (Warthin-Starry stain x 1,000).

DISCUSSION

This case illustrates some of the difficulties encountered in the diagnosis of syphilitic gastritis. This represents the first case recognized at MBMC. Since that time we have had experience with two other cases. All were in their twenties or early thirties and presented with hematemesis. On all cases the endoscopic impression was lymphoma. All were confirmed by appropriate serologic testing.

This is a difficult diagnosis for pathologists since the inflammatory infiltrate is nonspecific in character. The use of silver stains is common in the evaluation of gastric biopsies and the same preparation (Warthin-Starry) used to detect Helicobacter Pylori also stains spirochetes. These organisms may be difficult to see and their concentration varies widely from area to area. Repeated careful examination of the first biopsy did not reveal any organisms even though they were readily seen in the second set of biopsies from only a few days later. There exists also the possibility of false positive diagnosis. Saprophytic spirochetes from the mouth may be seen in peptic ulcers but do not invade epithelium and lamina propria as do Treponema Pallidum.[3] An unusual bacteria called Gastrospirillum Hominis may mimic spirochetes on silver stain but should be distinguishable since it is noninvasive, thicker and shorter than spirochetes and visible on routine H&E staining.[4]

The gastroenterologist is also faced with a nonspecific or often misleading endoscopic appearance. Several helpful clues do exist. It should be kept in mind that gastric lymphomas are relatively uncommon in young adults and are usually of a high grade type and readily recognized microscopically. Based on our limited experience, conventional anti-ulcer therapy in syphilitic gastritis has not been of any benefit. As in this case, careful physical exam will often show other indicators of syphilis.[2] In fact, one of our later cases had a chancre. Finally, since these cases have all been examples of secondary syphilis, serologic tests have a high likelihood of being positive. One caveat is that one should never rely on a negative silver stain to rule out syphilitic gastritis as illustrated by the first biopsy in this patient.

In summary, we present a case of hemorrhagic gastritis, an unusual and poorly documented manifestation of secondary syphilis. The fact that we have seen three such cases in one year suggests that the incidence of this is higher than generally appreciated. Endoscopic and microscopic data are often either nonspecific or frankly misleading. Once the correct diagnosis is considered it is easily confirmed by serologic testing. This has also been noted in

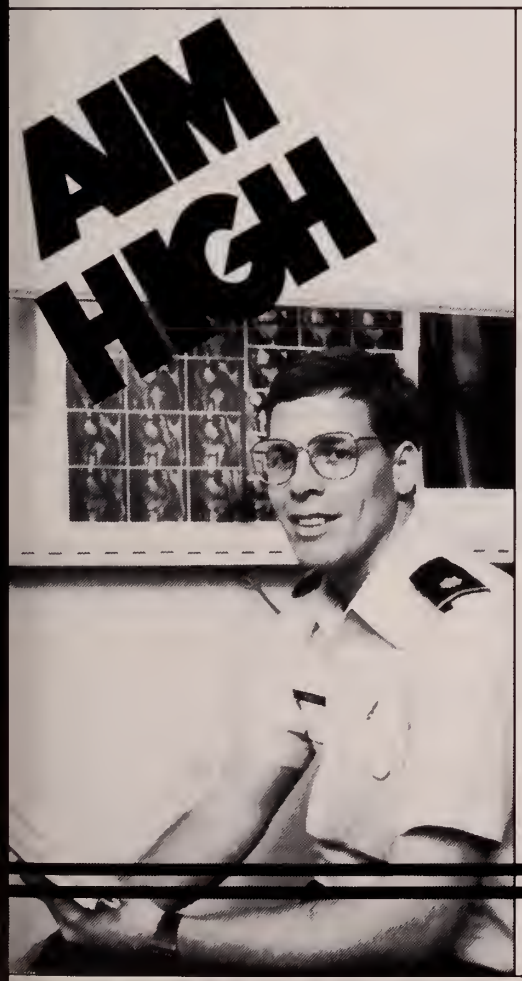
the few other patients reported in the literature. ❑

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***Dr. Wetzel** is a Pathologist, and **Margaret Tharp** is a Medical Technician at Mississippi Baptist Medical Center. **Dr. Long, Dr. Johnston**, and **Dr. Hayden-Wright** are in private practice with Gastrointestinal Associates, Jackson, MS.*



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Laparoscopic Nephrectomy A Case Report

W. Bruce Shingleton, MD

Laparoscopy has only recently begun to be performed by urologists. The initial urologic procedure to have been performed via laparoscopy was a pelvic lymphadenectomy for carcinoma of the prostate.[1] As urologists have gained experience with this technique other urologic procedures have been performed with laparoscopy are varicocele ligation, bladder neck suspension, adrenalectomy and nephrectomy.[2] This paper reports the first laparoscopic nephrectomy performed in Mississippi.

CASE REPORT

A 55 year old black female with poorly controlled hypertension on three antihypertensive medications underwent evaluation to determine the possible etiology of her disease. An intravenous pyelogram was obtained and demonstrated a nonfunctioning left kidney. The patient denied any previous history of surgery, infection or trauma to the kidney. Subsequently, renal vein renin samples were obtained and an elevated renin level from the left renal vein sample was found to be present. At this point it was felt that the nonfunctioning left kidney was the source of her hypertension and the patient elected to proceed with a left simple nephrectomy.

At the time of the operative procedure, the patient was placed in full flank position and a pneumoperitoneum attained with placement of a Veress needle. A 10 mm trocar was placed in a supraumbicial position and four additional 10 mm trocars were placed under direct vision over the left flank region. The left colon was reflected medially after sharp incision over the lateral aspect. A ureteral catheter had been placed preoperatively and this aided in identification of the left ureter. The ureter was dissected clear and followed up to the renal hilum where the renal artery and vein were identified. The artery and vein were separately secured with metal clips and sharply divided. The kidney was sharply dissected free and clear of the surrounding tissue and brought out intact through an extended trocar site (Figure 1). Total operating



Figure 1. Left kidney

time was four hours and estimated blood loss was 100 cc. The patient had an uneventful postoperative recovery and discharged on the second postoperative day. At the time of discharge the patient's hypertension was well controlled on two medications.

DISCUSSION

Laparoscopy offers numerous advantages over open surgical procedures. These include decreased hospitalization time, decreased recovery to pre-operative status, decreased use of the pain medication and decreased risk of wound infection. As the technological advances occur in laparoscopic instrumentation the number of urologic procedures available to laparoscopy will increase. With a decrease in the hospitalization time and recovery period, the cost savings to the health care system will be signifi-

cant. While it has been stated that laparoscopy is a technology looking for a procedure, the statement should rather be that in the near future procedures will be looking to be performed via laparoscopy. ❑

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Dr. Shingleton, is in the Division of Urology, Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

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Timing of Prophylactic Antibiotics In Selected Surgical Procedures

Candace E. Keller, MD, MPH
Alton B. Cobb, MD, MPH
Belinda Moseley, BS

As part of the Health Care Quality Improvement Program, the Foundation for Medical Care implemented a project concerning the use and timing of prophylactic antibiotics in selected peripheral vascular and orthopedic surgical procedures. These procedures included aortic aneurysmectomy; aorta-iliac-femoral bypass; femoral-popliteal bypass; total, partial or revision hip replacement; and total or revision knee replacement. This project was developed with advice from a study group comprised of Mississippi physicians specializing in surgery and infectious diseases.

As a result of numerous controlled clinical studies conducted during the past two decades, it has been well established that appropriately administered antibiotic prophylaxis reduces the risk of postoperative infection by about 50% when compared with comparative untreated patients.[1] Wound infections are among the most common nosocomial infections among hospitalized surgical patients and are the second or third most common nosocomial infections among all hospitalized patients. Surgical wound infections result in the administration of more antibiotics, an increase in the cost of care, and a prolongation of hospital stay.[2] Studies have shown that a maximum prophylactic effect is achieved when antibiotics are administered within a two-hour timeframe before the surgical incision.[3]

METHODS

This study was undertaken to examine the effectiveness of current prophylactic antibiotic administration processes in achieving optimal timing in the selected surgical procedures. The study consisted of 776 Medicare patients who had one of the surgical procedures performed between May 1, 1993, and April 30, 1994. All cases performed in this timeframe were reviewed. Seven Mississippi hospitals participated with the Foundation in this project.

RESULTS

A total of 141 peripheral vascular cases were reviewed from four of the seven participating hospitals. The other three hospitals either had a low volume of peripheral vascular cases or these procedures were not performed. Of these cases, 49 were excluded because the patient received an antibiotic 12 hours or more prior to procedure. (These cases were excluded because of the possibility that the patient was receiving routine antibiotics for a reason other than prophylaxis.) Of the remaining 92 cases, 88 (95.65%) received antibiotics with only 30 (34.09%) receiving the antibiotic within two hours prior to surgery.

A total of 645 orthopedic cases were reviewed from the seven participating hospitals. Of these

cases, 27 were excluded because the patient received an antibiotic 12 hours or more prior to the procedure and therefore did not meet the definition of prophylactic antibiotics. Of the remaining 608 cases, 603 (99.18%) received antibiotics with 427 (70.81%) receiving the antibiotic within two hours prior to surgery.

CONCLUSION

For all procedures, 66 percent of patients received antibiotics within the optimal two-hour time period before surgery. Optimal usage of prophylactic antibiotics was much higher for orthopedic cases than for peripheral vascular cases (Table I). An analysis of the data revealed that patients admitted to the hospital before the day of surgery were more likely to receive antibiotics within two hours prior to surgery than patients who were admitted on the same day of the procedure. Patients who had the surgery between 6:00 a.m. and 9:00 a.m. were more likely to receive antibiotics within the two-hour time frame than patients who had surgery performed later in the day. The patients who had surgery after 9:00 a.m. may have been given antibiotics within two hours prior to the scheduled surgical time but because of delays in surgery, the antibiotic timing may have fallen out of the optimal time for administration. Other process factors may be involved as well (Table II).

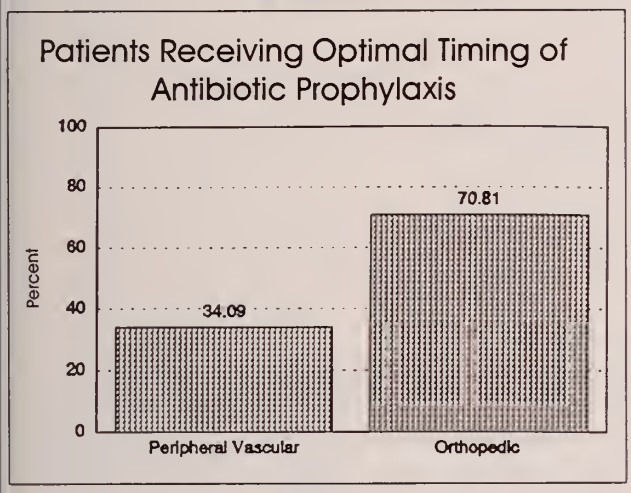


Table I

The results of this study suggest there are significant opportunities for improvement in the timing of prophylactic antibiotic administration prior to surgery. These improvements can be achieved by studying the current hospital process and making modifications where indicated within the system. The results of this study have been shared with the participating hospitals and physicians. The hospitals and their medical staffs are submitting clinical improvement plans which address the specific processes of care in each facility. Measurement of this quality indicator will be monitored over time.

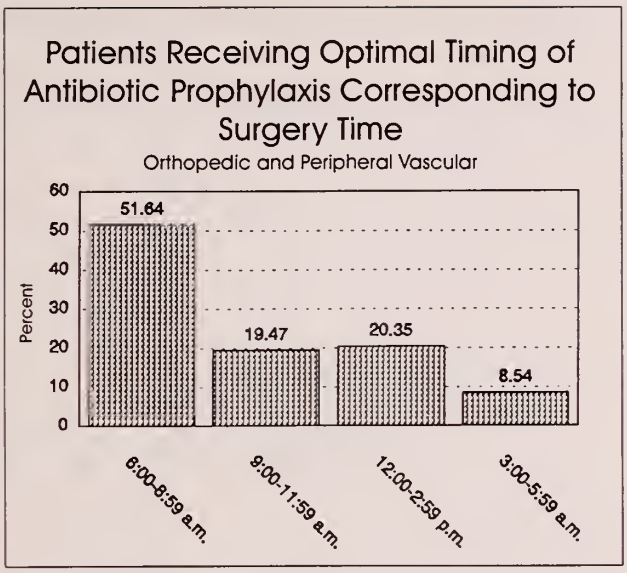


Table II

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Dr. Keller, *the Foundation's consulting clinical coordinator since 1994, coordinates study projects designed to improve the quality of care for Medicare patients. She is an anesthesiologist in Hattiesburg.* ***Dr. Cobb,*** *principal clinical coordinator for two and a half years, served as state health officer for 20 years before joining the Foundation.* ***Belinda Moseley****, the Foundation's health planner, joined the staff in 1994. She studied community health education at USM.*

Address of the President

It Was A Very Good Year

To borrow a line from Ole Blue Eyes. Yes! It was a very good year! We have seen the rise and then the demise of the Clinton Comprehensive Health Care Reform Plan. A plan that would have devastated our patients, ourselves, and our country.

We have seen the U.S. House of Representatives pass a bill that puts a cap on non-economic damages in medical liability cases. Although this effort ultimately failed in the Senate, just getting the issue to a vote in both houses for the first time represents a significant accomplishment for organized medicine. At last, the first step in bringing some common sense into the tort system in this country.

"Thank yous" go for the efforts by the AMA and help from Mike Parker, our other representatives, with the exception Bennie Thompson, who voted against us and both our Senators.

Back at home, Governor Fordice has signed into law the "Patient Protection Act" which is the first step in bringing the hurricane of "managed care" that is descending on our state into a controlled wind that will treat patients and physicians fairly. Thanks to much hard work and dedication by our Lobbyist—Charmain Thompson and our Council on Legislation, chaired by Dr. John Lucas this bill was passed. It had been killed five times and resurrected five times by our people.

Think about it! What we as the AMA and the MSMA are working toward is finally showing positive results. The doom and gloom of last year has changed into a glimmer of brilliant promise that we can only hope will expand into a beautiful bright morning of just, reasonable and appropriate treatment of our patients and the physicians who care for them.

In the future, perhaps the light will expand to include Congressional hearings on the subject of "managed care" and whether it is truly in the best interest of the American public. Or is it more of a benefit to the financial interests of the large managed care companies and the Insurance industry— with our patients getting short changed so that these companies can amass huge profits. An investigation was suggested by House of Representative's Speaker Newt Gingrich at the AMA leadership conference in Washington this past March.

Again, in Mississippi, Governor Fordice has expressed concern, in a personal conversation, about a member of our Supreme Court and a desire, if the opportunity presents itself, to see that the court is less biased in the future.

But this means that we, the physicians of Mississippi, must continue to increase our involvement in the political process. We can no longer be apathetic about who is elected to the U. S. Senate and House of Representatives,

the Mississippi Legislature, or the state Supreme Court.

Like it or not, the practice of medicine and the welfare of our patients is in the hands of "government" and if we are not diligent (no! more than diligent-adamant!) in our efforts to educate our elected representatives then we will have only ourselves to blame for the bad results. Those in government who cannot be brought into enlightenment as to the plight of our patients and ourselves must be replaced by new representatives so an equality and fairness exists for all. We are making steps in the right direction. Its up to all of us to see that the progress continues.

On a more personal note, it has also been a very good year for me! In the first place, I was married during the year and am blissfully happy!

And I have had a very good year for other reasons. I have truly enjoyed my visits to the various component societies, Visiting with my colleagues and old friends, and meeting new friends. It has been all exciting and heart warming experience.

I have enjoyed the opportunity to share some of my thoughts through the President's Page in the MSMA Journal and hope that you have enjoyed reading them. Even more, I hope that you agree with at least a few of them.

But, Hey!, I'm only human, and it's also been a real thrill to be the president of an organization worth millions of dollars. I don't know if you are aware of it, but MSMA has several subsidiaries. These are: MSMA Services which owns and manages our building; Mississippi Physician Insurance Company (MPIC) which is our insurance company that handles workman's compensation insurance; Mississippi Physicians Care Network (MPCN) which is our PPO that is entering into the managed care market; MSMA Foundation which is our charitable and educational arm; MSMA Diversified Services which is our for profit subsidiary providing tangible services and benefits to MSMA members; and the Benefit Plan and Trust which provides health benefit coverage for our members, their employees, and their families.

MSMA is more than just a good ole' boys club, it is a large conglomerate of diverse entities designed to serve and benefit our members. I have to thank all of you for giving me the privilege of presiding over all of these entities for the past year. But then maybe you wouldn't have elected me if you had known how big we really are. Well it was done, and MSMA and all of our subsidiaries are doing well, thank you.

This brings me to what is still left to be done. You and I, have to become more involved in government. We cannot leave it to the other guy. Like it or not, Federal and State governments will decide how we practice medicine, treat patients, order tests, admit and discharge the sick, and run our offices. We have to be players in this game and write or call our representatives when there is legislation that affects us. Believe me, if enough of us contact them, they will listen. If they don't listen, support MMPAC, and we will do our best to replace them with someone who will! Let's get the cap on non-economic damages passed in the Congress before the 1996 elections and let's push for more Tort Reform in the future. And let's get the antitrust laws changed so that we can really compete in the marketplace with the insurance companies and for-profit managed care industry. In our own home towns lets encourage our local hospitals to sign up with MPCN and talk to the people we know in local industry to at least listen to our MPCN proposal. It should be in their best interest and our best interest.

In closing, I want to thank the MSMA staff for all the help, support, and encouragement they have given me this past year. This includes Charlie, Bill, Dona, Charmain, Ginger, Jackie, Barbara, Lora, Jennifer and Virginia.

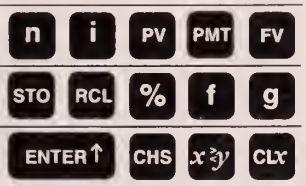
I also want each of you to know that I have sincerely enjoyed my year as president—thanks to your support. I know that you will extend the same support to your new President, Dr. Stanley Hartness. Thank you again, for "A Very Good Year" !

Mallan G. Morgan, M.D.

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D. Stanley Hartness, Jr., MD

The President's Page

Breaking The Silence

The effect was chilling... Nicole Brown Simpson's voice of hopeless resignation punctuated by O. J.'s background rantings. It was indeed the tape epitomizing domestic violence heard 'round the world.

Even more chilling are those cases of domestic violence in our own practices that go undetected... Mrs. Reticent whose husband insists on remaining in the exam room and answers all questions directed to her... Mrs. Noshow who repeatedly misses appointments... Ms. Shiner who attributes her black eye to a runaway wand at the car wash...

Domestic violence is generally defined as physical, verbal, and/or emotional abuse of a woman by an intimate partner, typically a current or ex-husband or boyfriend. While approximately two million women are severely assaulted by male partners annually in the United States, more than 27,000 Mississippi women called crisis lines between June l, 1993, and June 30, 1994, and more than l,000 women and 1,500 children were served in domestic abuse shelters in our state.

Family violence occurs among persons within family or other intimate relationships and includes child abuse and elder abuse as well as domestic violence.

Addressing a problem of this magnitude requires the expertise, time, and dedication of a wide variety of professionals. Until now, interventions have focused on shelters, police response, legal action, and legislation. But now we as physicians must become more involved in recognizing domestic abuse as a health problem and in assuming greater roles in addressing this subject among our patients.

The AMA's Council on Scientific Affairs has recently published health care goals for identifying and treating suspected domestic abuse victims. With a phone call to the AMA National Medical Resource Center (312/464-5066) along with a three dollar donation, you will receive invaluable materials on the diagnosis and

(continued on page 172)

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVI, NUMBER 6
JUNE 1995

Utilization Review Law of the State of Mississippi

At the recent 127th Annual Session of the MSMA there were many comments and questions regarding utilization review activities in Mississippi. A significant number of members ask that the subject again be addressed in the Journal.

There are two important sources regulating utilization review in this state:

1. Senate Bill 2393 of 1990: Utilization Review Law of the State of Mississippi.
2. Regulations for Certification of Utilization Review Agents in Mississippi. These regulations were written and promulgated by the State Health Department for implementation of the above law.

The key points in these documents are:

1. Senate Bill 2393 of 1990, Article 41-83-3:

Paragraph (1); "A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case by case basis, may not conduct utilization review in this state unless the Mississippi State Department of Health has granted the private review agent a certificate".

A nontransferable number is issued to each reviewing entity on certification. A list of agencies certified and their number is available on request from the Mississippi State Department of Health.

2. Part V (3) (f) of the Regulations:

Each private review agency shall submit the following documentation, "The policies and procedures to ensure that a representative of the private review agent is accessible to patients and providers five (5) Days a week
during normal business hours in this state, 9 A.M. to 5 P.M.; and that a free telephone number be provided with adequate lines available and staffed. The procedure for handling after-hour calls shall be specified".

3. Senate Bill 2393 of 1990, Article 41-83-31

Paragraph (a): No determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of hospital, medical or other health care services without prior evaluation and concurrence in the adverse determination by a physician. The reasons for any adverse determination shall be discussed by said physician with the affected health care provided, if the provider so request".

Paragraph (b): Any determination regarding hospital, medical or other health care services rendered or to be rendered to a patient which may result in a denial of third party reimbursement or a denial of pre-certification for that service shall include the evaluation. Findings and concurrence of a physician trained in the relevant specialty or subspecialty, if

(continued on page 172)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(President's Page continued from page 170)

treatment of domestic abuse as well as a membership in the National Coalition of Physicians Against Family Violence. Placards and posters for exam room display will identify you as a physician committed to the detection and treatment of domestic violence.

The AMA Alliance will launch a nationwide health promotion in June called SAVE, Stop America's Violence Everywhere. Our own MSMA Alliance in cooperation with our association is developing a directory of Mississippi domestic abuse shelters for our membership to facilitate appropriate referral of abuse victims. Check your mail closely for this timely resource.

Family violence doesn't just happen to other people; it happens to our patients and in our own families. And it's a problem that doesn't cure itself. When we as physicians allow such victims to break their silence, we then allow the cure to begin.

Stanley

(Editorial continued from page 171)

requested by the patient's physician, to make a final determination that care rendered or to be rendered was, is, or may be medically inappropriate".

4. Senate Bill 2392 of 1990, article 41-83-21

"Notwithstanding language to the contrary elsewhere contained herein, if a licensed physician certifies in writing to an insurer within seventy-two (72) hours an admission that the insured person admitted was in need of immediate hospital care, such shall constitute a prima facie case of the medical necessity of the admission. To overcome this, the entity requesting the utilization review and/or the private review agent must show by clear and convincing evidence that the admitted person was not in need of immediate hospital care".

To assure adherence to the above law and regulations physicians should consider the following:

1. Do not discuss any patient related information with anyone asserting to being a utilization reviewer until you have first obtained the certification number for that agent to do business in this state. To do so could be considered a breech of the patient-physician confidentiality laws.

2. Record the certification number of the review agent in the patients chart, documenting the conversation.

3. Understand that all decisions have to be made by a physician, not a nurse or other paramedical persons.

4. If a physician provider does not want to talk to a nurse or other paramedical persons then he/she must request to talk with the physician reviewer for the review agent, and if desired talk to a physician board certified in his specialty or subspecialty. If such a request is made for a discussion with the agent's reviewing physician the nurse cannot render a decision in the case, and must refer you to the physician reviewer as requested.

5. Exercise your right to notify an insurer in writing within seventy-two (72) hours of an emergency admission and thereby transfer to the insurer the responsibility of providing that the admission was not an emergency rather than you having to prove that it was.

6. This law, and the regulations, do not apply to medicare and medicaid patients.

It is recommended that each physician obtain, review and thoroughly understand the above law and regulations, and know what your responsibilities and legal obligations are in responding to utilization reviewers.

Myron W. Lockey, MD
Editor



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Medical Assurance Company of Mississippi

Risk Management Discount Program Update

Medical Assurance Company's 1995 Risk Management Discount Programs are well underway, and attendance at all programs held during April and May far surpassed our expectations. Upcoming programs are listed below. If you have not registered, please do so immediately. Seating is limited in most instances, and registration is accepted on a first-come, first-served basis. There is no registration fee.

Eligible physicians who participate in these programs during 1995 will receive a discount off their 1996 premiums.

If you have any questions about the risk management discount programs -- or about any of the other discounts offered by Medical Assurance Company, please call Cathy Pendleton at 601-353-2000 or toll free at 1-800-325-4172.

Risk Management in the Hospital Setting (10% Discount)

City	*Hospital*	*Program No.*	*Date*	*Time*		
Clarksdale	Northwest Regional Med Ctr	#101	August 2	1:30pm	to	3:00pm
Greenville	Delta Regional Medical Ctr	#104	June 27	6:30pm	to	8:00pm
Gulfport	Gulfport Memorial Hospital	#105	Sept. 7	6:00pm	to	7:30pm
Hattiesburg	Methodist Hospital	#107	June 15	7:00am	to	8:30am
Jackson	MS Baptist Medical Ctr	#109	August 15	6:00pm	to	7:30pm
Jackson	MS Baptist Medical Ctr	#110	Sept. 27	6:00pm	to	7:30pm
Jackson	River Oaks Hospital	#111	June 26	6:00pm	to	7:30pm
Jackson	River Oaks Hospital	#122	July 26	7:00am	to	8:30am
Jackson	River Oaks Hospital/East	#112	July 17	7:00pm	to	8:30pm
Meridian	Jeff Anderson	#114	June 13	5:30pm	to	7:00pm
New Albany	BMH/Union County	#116	August 14	6:00pm	to	7:30pm
Oxford	BMH/North Mississippi	#117	June 6	6:00pm	to	7:30pm
Starkville	Oktibbeha County Hospital	#118	July 11	6:30pm	to	8:00pm
~~Tupelo~~	~~North MS Medical Ctr~~	~~#119~~ **FULL**	~~June 6~~	~~6:00pm~~	~~to~~	~~7:30pm~~
Tupelo	North MS Medical Ctr	#120	June 7	6:00pm	to	7:30pm
Tupelo	North MS Medical Crt	#121	Sept. 19	6:00pm	to	7:30pm

Risk Management Basics (5% Discount)

City	*Hospital*	*Program No.*	*Date*	*Time*		
Corinth	Magnolia Regional Health Ctr	#501	April 4	6:30pm	to	7:30pm
Greenville	King's Daughters Hospital	#502	April 11	6:00pm	to	7:00pm
Jackson	Methodist Medical Ctr	#503	July 12	12:00N	to	1:00pm
~~Jackson~~	~~University of MS Medical Ctr~~	~~#504~~ **FULL**	~~July 18~~	~~4:00pm~~	~~to~~	~~5:00pm~~
Jackson	University of MS Medical Ctr	#505	July 25	4:00pm	to	5:00pm
Jackson	University of MS Medical Ctr	#506	Sept. 18	4:00pm	to	5:00pm
Natchez	*Location To Be Announced*	#508	Sept. 5	7:00pm	to	8:00pm
Pascagoula	Singing River Hospital	#510	June 1	12:00N	to	1:00pm
Pascagoula	Singing River Hospital	#511	June 1	6:00pm	to	7:00pm

MSMA 127th Annual Session



D. Stanley Hartness, MD, of Kosciusko, center, was installed as 1995-96 MSMA President during the closing session of the MSMA House of Delegates on Sunday, May 21. Fred L. McMillan, MD, of Jackson, left, was named president-elect. Mallan G. Morgan, MD, of Natchez, right, is immediate past president of the Association.

Dr. Hartness Installed as Association President; Dr. McMillan Named President-Elect

D. Stanley Hartness, MD of Kosciusko a family physician was installed as 1995-96 president of the Mississippi State Medical Association and **Fred L. McMillan, MD** of Jackson an ophthalmologist was named president-elect during the closing session of the 127th MSMA Annual Session held May 17-21, 1995 in Biloxi, Mississippi.

Dr. Hartness, a member of the association since 1969 has served the MSMA as a member and past chairman of the Council on Medical Education; a member of the Council on Medical Services; a member and chairman of the Council on Public Information; a member of the Board of Trustees; Chairman of the MSMA Council on Scientific Assembly; Secretary-Treasurer and President-elect. He is also a member and past president of the MS Academy of Family Physicians.

Dr. McMillan has served the association as a member of the Board of Trustees of which he has served as secretary-treasurer, and as an alternate delegate to the AMA. He has also served as President of Central Medical Society.

Elected Officers, Board and Council Members

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Fred L. McMillan, MD, Jackson

SECRETARY/TREASURER
Candace E. Keller, MD, Hattiesburg

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Don Q. Mitchell, MD, Jackson
J. Edward Hill, MD, Tupelo
James C. Waites, MD, Laurel

ALTERNATE DELEGATE TO AMA
Candace E. Keller, MD, Hattiesburg
George E. McGee, MD, Hattiesburg
Jim Fuller, M4, Jackson

EDITOR, JOURNAL MSMA
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Robert E. McAfee, MD, President of the American Medical Association addressed the opening session of the MSMA House of Delegates.



Stanley Hartness, MD received his presidential pin from **Eric Lindstrom, MD**, chairman of the MSMA Board of Trustees.



Fred L. McMillan, MD, an ophthalmologist practicing in Jackson was elected to the office of President-Elect.

Actions of the House of Delegates 127th Annual Session

MSMA's House of Delegates considered reports from the Board of Trustees and Councils as well as numerous resolutions.

Delegates elected by MSMA's component societies considered the reports and resolutions.

Among actions taken by the Delegates were the following:

- Urged all members to participate in and support the Mississippi Physicians Care Network (MPCN) and to urge their local hospitals to the same.
- Noted the alarming increase in traffic accident deaths and injuries among children and directed that this be conveyed to the public.
- Urged the AMA to study cost, quality and regulatory issues of non-physician health care providers.
- Directed the MSMA Board of Trustees to study and act on recommendations regulating the practice of physician extenders in Mississippi.
- Urged all MSMA members to seek representation of their respective hospital, PHO, HMO or IPA medical staff at semi-annual meetings of the AMA Hospital Medical Staff Section. This years meetings will be held June 15-17 in Chicago and November 30 - December 2 in Washington, D.C.
- Urged that Mississippi become a statewide Medicare fee area and directed the Board of Trustees to obtain support for same from MSMA's component societies as well as state specialty societies in accordance with Medicare guidelines.
- Urged hospital medical staff to adopt stated guidelines for peer review activities.
- Urged the AMA to continue to utilize appropriate public and physician survey data in formulating health policy.
- Urged the MSMA Board of Trustees to study the effects of proposed Medicaid Block Grants on the Mississippi Medicaid Program.
- Directed that MSMA publicize the availability and benefits of local hospice care facilities.
- Urged that all pregnant women be offered HIV testing at their first prenatal visit.
- Urged that all pregnant women be serologically screened for syphilis prenatally and that the new born infant be tested before hospital discharge.

Members serving on Reference Committees of the House were:

Reference Committee on Constitution and Bylaws:

Eugene G. Wood, MD, Chair
Jackson
David G. Hall, MD,
Natchez
Marsha Gale Lucas, MD, PhD,
Greenwood

Reference Committee A on Reports of Officers, Board of Trustees and Councils:

Daniel P. Edney, MD, Chair,
Vicksburg
Virginia M. Crawford, MD,
Hattiesburg
Mark Strong, MS4,
Jackson

Reference Committee B on Reports of Officers, Board of Trustees and Councils:

L. Susan Buttross, MD, Chair,
Jackson
Steven C. Brandon, MD,
Starkville
Ben M. Carmichael, MD,
Hattiesburg ❑

H. Vann Craig, MD, of Natchez, Speaker of the MSMA House of Delegates presided over the Thursday, May 17, opening session.



Below, **Samuel Gelfrand, MD**, Chairman of AMPAC, right, presented **Eugene Wood, MD**, MMPAC member, left, the following first place AMPAC awards: Greatest percentage increase in overall membership, greatest percentage increase in revenue, greatest percentage of members to potential, and highest percentage of sustainer members.





Jim Fuller, MS4, of Jackson, far left, was the recipient of The Carl Gustav Evers Award. **Mal Morgan, MD**, MSMA President, right, presented the award.

The Carl Gustav Evers Award is given annually by the MSMA Foundation on behalf of the many friends and colleagues of Dr. Carl Evers, a past president of the association, member of the AMA Council on Medical Education and associate dean of academic affairs in the School of Medicine and presented to the senior medical student who has demonstrated qualities of peer to peer support, scholarship and exceptional leadership in promoting and participating in student activities of The American Medical Association.

Damea Benton, MD, left, was the recipient of the Medical Assurance Company of Mississippi 14th Annual Robert S. Caldwell Memorial Award. The award was present by **Earl Fyke, Jr., MD**, MACM Medical Director, right.

Dr. Benton, a senior resident in Pediatrics at the University of Mississippi Medical Center, was chosen unanimously by an ad hoc committee of UMC faculty, in recognition of her in-training excellence including medical practice, patient relations, and documentation of patient care.

The Caldwell Memorial Award is presented by Medical Assurance Company each year, in the interest of furthering medical-legal education in Mississippi and in memory of Robert S. Caldwell. Dr. Caldwell, a general surgeon from Tupelo, was instrumental in the formation of MACM. He served on MACM's first Board of Directors, and was elected the company's first Secretary. Dr. Caldwell was MSMA's president-elect at the time of his death.





MSMA President, **Mal Morgan, MD**, above right, presented the Awards for Excellence in Medical Reporting. **Ms. Fleeta Sneed**, above left, of the New Albany Gazette, was recipient of an award presented for excellence in the newspaper category.

Mr. Kevin Farrell, with Public Radio in Mississippi received the media award in the radio broadcast category.



Mr. Bill Zimmerman, below, editor of Healthbeat Magazine a publication of The Clarion-Ledger received a media award for excellence in the Newspaper Category for his publication.



Ms. Melanie Christopher, left, News Anchor for WLBT-TV 12, Jackson, received a media award for excellence in the television category.



During the annual Membership Party the MSMA Alliance held a silent auction to raise funds for AMA-ERF. The auction tables and easels were loaded with art, pottery, stained glass, quilts, specialty foods and children's items. There was artwork by Yvette Sturgis, Opal Smith, Bill Gates and Walter Anderson as well as glass by Susan Ford and a complete set of specially signed John Grisham books. Members also had the opportunity to take a $5.00 chance on a football autographed by Archie Manning.

Above, **Elizabeth Craig** of Natchez paid Auction Chairman, **Melanie Moore** of Pascagoula and Alliance members, **Rose Lee Robinson** of Jackson and **Sandy Guice** of Hattiesburg for a painting purchased during the auction.

At right, during the party, MSMA members and their guests had the opportunity to browse through the many items available for auction.





At right, **Buddy Spencer, MD** pays for the items he purchased during the auction.

MSMA President, **Mal Morgan, MD**, right, presented checks to **Helen Turner, MD**, Associate Dean of the medical school, left, on behalf of The Mississippi State Medical Association, The MSMA Alliance, and the University of Mississippi Medical Alumni Association.

The checks in the amount of $21,014.15 and $7,751,12 represent 1994 unrestricted and medical education contributions respectively to the University of Mississippi Medical School.





Roland Robertson, MD, left, of Jackson, was presented the $500.00 Exhibit Attendance Prize by **Candace Kellar, MD**, MSMA Secretary-Treasurer during the closing session of the MSMA House of Delegates.



Van Lackey, MD, with Jackson Oncology Associates, received the 1st place Aesculapius Award for their Scientific Exhibit entitled, "Steps to Cancer Pain Management".

Professional Liability in a Changing Practice Environment was the theme of the Educational Programs held Friday and Saturday mornings during the MSMA Annual Session.





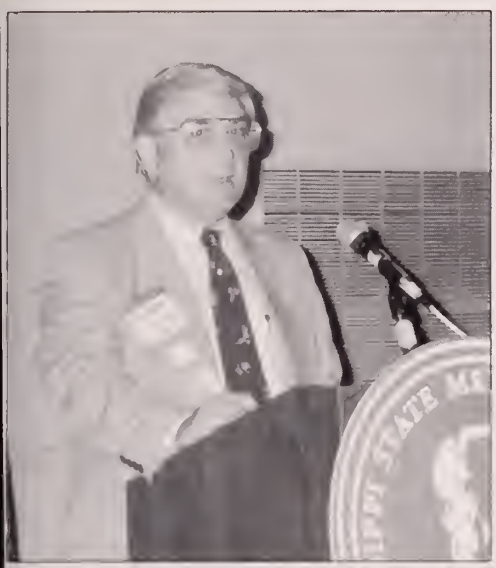
Below, **Robert Rhodes, MD**, far right, of Jackson served as chairman of the Saturday Plenary program. **Donald Palmisano, MD**, left, of Metairie, Louisiana and **Dean Griffen, MD**, center, of Shreveport, Louisiana were among the guest speakers.



John Moffitt, MD, above, of Jackson was chairman of the Friday Plenary Program.



More than 80 physicians attended each day of the plenary sessions.



Vann Craig, MD, of Natchez serves as Speaker of the MSMA House of Delegates.

Mary Gayle Armstrong, MD, right, of Madison served as Chair of the Reference Committee on Rules and order of Business





Daniel Edney, MD, left, of Vicksburg served as Chair of the Reference Committee A



George McGee, MD, of Hattiesburg serves as Vice-speaker of the MSMA House of Delegates.

Susan Buttross, MD, right, of Jackson served as Chair of the Reference Committee B





Eugene Wood, MD, of Jackson served as Chair of the Reference Committee on Constitution and Bylaws



MSMA Members listen to the reports of the Reference Committees during the closing session of the House of Delegates



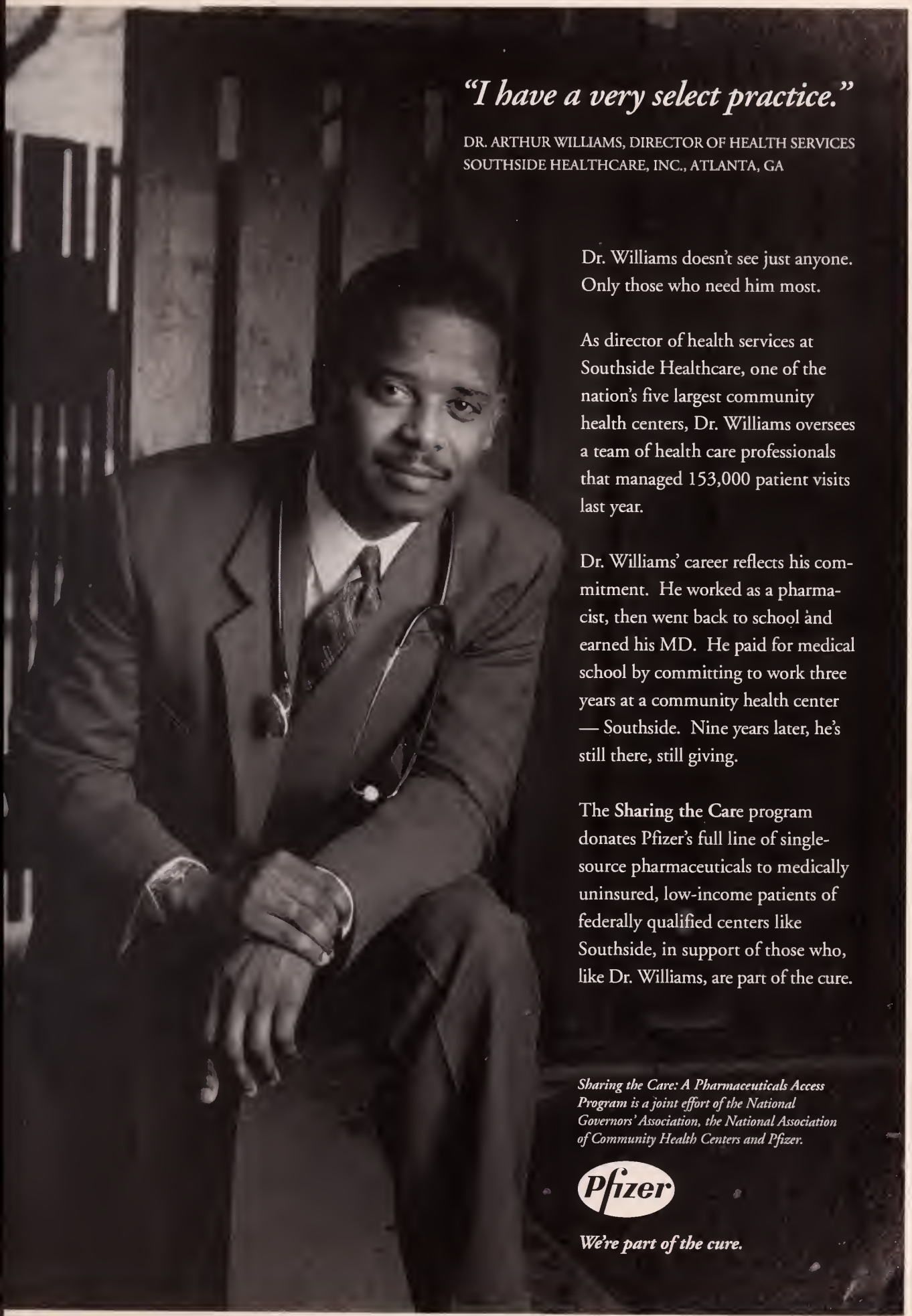
Stanley Hartness, MD, right, of Kosciusko, received the oath of office as MSMA President from Chairman of the Board of Trustees **Eric Lindstrom, MD**, left, of Laurel. **Charles Mathews**, MSMA Executive Director, center, held the Bible as the oath was given.



MSMA President, Stanley Hartness, MD, addressed the House of Delegates after the installation ceremony.



Mal Morgan, MD, left, of Natchez, was presented his past president's pin by **Dr. Hartness**.



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DR. ARTHUR WILLIAMS, DIRECTOR OF HEALTH SERVICES
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Dr. Williams' career reflects his commitment. He worked as a pharmacist, then went back to school and earned his MD. He paid for medical school by committing to work three years at a community health center — Southside. Nine years later, he's still there, still giving.

The **Sharing the Care** program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Southside, in support of those who, like Dr. Williams, are part of the cure.

Sharing the Care: A Pharmaceuticals Access Program is a joint effort of the National Governors' Association, the National Association of Community Health Centers and Pfizer.

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We're part of the cure.

Bicycle Safety Program Awards Presented

The 1995 Carl G. Evers Memorial Bicycle Safety Program was sponsored this year by MMRC, The Mississippi State Department of Health, The Bike Rack and The Mississippi State Medical Association. The Awards ceremonies were held, May 3 at MMRC.

More than 2,500 fourth and fifth graders in 9 metro Jackson schools participated in the event, which educated the children about bicycle safety and had them create a bicycle safety poster.

The grand prize winners were Missy May a fourth grader from Madison Ridgeland Academy and Len Clark a fourth grader at Jackson Academy. Each received a brand new bicycle, and bicycle helmet with rear view mirror. The posters were judged by WLBT's Bert Case, The Clarion-Ledger's editorial cartoonist Mark Bolton, Jan Evers, wife of the late Dr. Evers for whom this event is named, local artist Sandra Williams and Tom Martin of The Bike Rack. Tiffany Usry, a fifth grader from Eastside Elementary, was the second place grand prize winner and received a cyclometer. Kimberly Howard, a fifth grader from Isable Elementary was the third place grand prize winner and received an air pump.

In addition, the first place winners from 112 classrooms each received a bicycle helmet and the second place winners, a t-shirt. The winners from each school's contest received rear-view helmet mirrors, provided by MSMA for first place, identification shoe pockets provided by the MSMA Alliance, for second place and safety t-shirts for third place.

Head injuries account for 62% of bicycle related deaths, for 33% of bicycle-related injuries resulting in emergency room visits, and for 67% of bicycle related hospital admissions. The use of helmets works in the prevention of head injury among bicycle riders, thereby reducing the number of riders who are killed or disabled. Each year in the U.S. 50,000 children sustain bicycle-related head injuries. Of these 400 die. Medical cost incurred by injured bicyclists average more than $1,000. Lifetime costs for a severely head injured bicyclists average more than $4.5 million.❑



MSMA President, Mal Morgan, MD, left, and Mrs. Jan Evers, right, congratulate Missy May, center, the girls division Grand Prize Winner.



MSMA President, Mal Morgan, MD, left, and Mrs. Jan Evers, right, congratulate Len Clark, center, the boys division Grand PrizeWinner.

RRC Among First To Use New Format

The Residency Review Committee (RRC) of the University of Mississippi Medical Center's School of Medicine is among the first intra institutional review committees in the United States to use the new 1995 Accreditation Council for Graduate Medical Education (ACGME) standards for evaluation of medical residency programs in a computer disc format, according to John Nylen, director of Information Services of the ACGME.

Campus-level residency review committees are institutional review boards set up to conduct internal program reviews of medical residencies. Internal campus reviews by a campus-level RRC are usually conducted before an external review by the ACGME accreditation team, which is also called an RRC.

Hard copies (better known as "the green book") of program requirements are distributed annually by the ACGME. The document lists the criteria used in accreditation reviews of residency programs. UMC's RRC had previously used hard copy versions of "the green book" for all of its internal reviews of residency programs.

The UMC residency review committee wanted computer versions of the accreditation standards to more accurately address the language of the ACGME in response reports without having to retype the standards.

Dr. Carol Scott-Conner, chair of the UMC RRC, used the new computer-formatted standards in a recent review of a residency program on campus. "The new format allows a reviewer to be more efficient in the use of time in evaluating a residency program," Dr. Scott-Conner said. "Knowing that we're among the first in the country to use the most current information in a computer format shows leadership in the field of residency education."

Nylen said that the success of the UMC RRC helps the national organization make decisions about offering additional services at the national level. "Because of requests like UMC's the ACGME is currently developing CD-ROM version of the program requirement that will be available for distribution in two or three years. ❑

465 Receive Degrees

The University of Mississippi Medical Center's 39th commencement is Saturday, May 27, at 4 p.m. at City Auditorium. Chancellor R. Gerald Turner, who has served as the institution head since 1984, is the speaker. He recently was named the new president of Southern Methodist University in Dallas and will assume duties on June 1.

Dr. A. Wallace Conerly, vice chancellor for health affairs and dean of the School of Medicine, and Mrs. Conerly will host a reception for graduates and their families at 1:30 p.m. in the Oglevee Building Auditorium.

There are 465 candidates for degrees this year. Included are 90 for the MD; 30 for the DMD; and 128 for the BSN. Ten students in the School of Health Related Professions are candidates for the bachelor of science degree in cytotechnology; 15 in dental hygiene; 11 health information management; 13 in clinical laboratory sciences; 22 in occupational therapy and 70 in physical therapy. Fifty-six graduate students expect to receive the MSN and 20 the PhD. ❑

UMC Team Wins "Relay For Life"

The University of Mississippi Medical Center "Fibrillators" took first place in the cancer society fund raiser, "The Relay for Life."

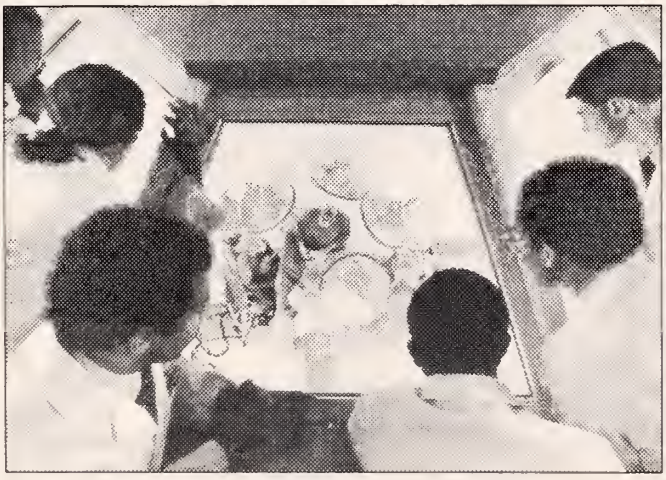
Twenty-one teams from the Jackson area competed in the 24-hour relay event held at Newell Field on April 28-29. UMC's team ran more than 117 miles during the 24-hour period and received the first place award for most laps completed by a running team.

The event, sponsored by the Hinds/Madison chapter of the American Cancer Society, raised money for the fight against cancer.

Members of the UMC "Fibrillators" are Dr. David Dzielak, Department of Surgery team captain, Marilyn Wade, Department of Medicine, Robin Kozlowski, Department of Pharmacology and Toxicology, Dr. Jackie Novak, Department of Physiology and Biophysics, Angie Planch, Quintus Jones, Deb Helmintoller, Jay Sanders, Department of Surgery, Ollie Brock, Division of Public Affairs, and Bo Martin, first-year medical student. Also, Benson Warnock, Mike Davis, Joe Marshell, CeCe Tucker, and Ann King from the Mississippi Track Club joined the UMC team for the event.

Fund raising for the team was coordinated by Suzanne Clay, administrative assistant in the Department of Medicine. ❑

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(504) 522-1871

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BERNHEIM, PETER J., Gulfport. Born April 30, 1961, MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned one year, University of Florida Medical Center, Jacksonville, FL; gastroenterology residency, same, 1991-93; elected by Coast Counties Medical Society.

BURWELL, JOHN S., Natchez. Born Milwaukee, WS, February 17, 1946; MD, Louisiana State University School of Medicine, New Orleans, LA, 1987; interned and anesthesiology residency, Charity Hospital, New Orleans, LA, 1987-91; elected by Homochitto Valley Medical Society.

BYERS, PAUL E., Jackson. Born Chicago, IL, December 18, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1992; interned one year, University Medical Center, Jackson, MS; elected by Central Medical Society.

FERRIS, EUGENE B., Vicksburg. Born Cincinnati, OH, January 16, 1943; MD, University of North Carolina School of Medicine, Chapel Hill, NC, 1969; interned one year and one year residency in surgery, Georgia Baptist Hospital, Atlanta, GA; surgery residency Maine Medical Center, Portland, ME, 1973-76; general surgery residency, Good Samaritan Hospital, Cincinnati, 1976-78; elected by West Mississippi Medical Society.

GRIENER, THAYNE C., Pascagoula. Born New Orleans, LA, June 25, 1955; MD, Louisiana State University School of Medicine, New Orleans, LA., 1982; otorhinolaryngology residency, Greater Baltimore Medical Center & Franklin Square Hospital, 1982-88; elected by Singing River Medical Society.

JOHNS, STEPHEN PAUL, Pass Christian. Born Gulfport, MS, June 30, 1960; MD, University of Mississippi School of Medicine, Jackson, MS, 1986; interned and family practice residency, Riverside Regional Medical Center, Newport News, VA, 1886-89; elected by Coast Counties Medical Society.

LOVELL, FRANK ALAN, Gulfport. Born Birmingham, AL, January 10, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; radiology residency University of Mississippi Medical Center, Jackson, MS, 1989-93; neuroradiology fellowship, University of Alabama Medical Center, Birmingham, AL, 1993-95; elected by Coast Counties Medical Society.



LOWRY, SLATER B., Columbus. Born October 10, 1957; MD, University of Alabama School of Medicine, Birmingham, AL, 1985; interned and family practice residency, Tulane University Medical Center, New Orleans, LA, & Mayo Clinic, Rochester, MN, 1986-92; elected by Prairie Medical Society.

MAZUR, RICHARD A., Long Beach. Born October 5, 1952; MD, Wroclaw Medical Academy, Poland, 1982; internal medicine residency, Ravenswood Hospital, Chicago, IL, 1983-86; elected by Coast Counties Medical Society.

MIZELL, WILLIAM L., Poplarville. Born Bogolusa, LA, October 13, 1946; DO, Kirksville College of Osteopathic Medicine, Missouri, 1993; interned one year in Texas. Elected by Pearl River Medical Society.

ROSS, WILLIAM SIDNEY ROBERT, SR., Moss Point. Born Gulfport, MS, January 12, 1943; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; family practice residency, Memorial Medical Center, Savannah, GA., 1989-92; elected by Singing River Medical Society.

REINSTATED:

HIATT, WARREN A., JR, Gulfport. ❑

Personals

Patty Duggar Allred of Jackson has completed formal certification in Addiction Medicine by the American Society of Addiction Medicine after completing a one year fellowship in the field at the University of Mississippi Department of Family Medicine. She is in private practice at "Our Healing Place" located at 1991 Lakeland Drive, Suite E, Jackson.

Tom Carey, of McComb, a pediatrician was reelected to the Blue Cross and Blue Shield of Mississippi Board of Directors.

John R. Harper of Taylorsville has completed continuing medical education requirements to retain Active membership in the American Academy of Family Physicians.

Thomas E. Joiner, of Jackson, a family practice physician, has been named Methodist Medical Center's Chief of Staff for 1995.

J. Keith Mansel has been appointed to a three-year term on the University of Mississippi Alumni Association board of directors. He is associate professor of medicine in the Division of Pulmonary Diseases, assistant professor of anesthesiology and director of respiratory therapy at UMC.

E. J. "Gene" Price, Jr. of McComb, an obstetrician and gynecologist at Southwest Clinic for Women has been elected chairman of the advisory board of Deposit Guaranty National Bank's operations in McComb.

Michael A. Reddix of Jackson has been named Chief of Medicine at Methodist Medical Center, Jackson.

F. H. Savoie, III, of Jackson presented Management of Ankylosis of the Elbow at the 1995 Perspectives on Small Joint Arthroscopy in Rosemont, Illinois in association with the American Academy of Orthopaedic Surgeons, April 20-22. He has also made the following presentations in association with the New York Medical College Department of Orthopaedic Surgery for the Current Concepts in Shoulder Reconstructive Surgery Course in Thornwood, New York, April 20-22, 1995: *Arthroscopic Treatment/Mini-Open Technique for Rotator Cuff Tears; Arthroscopic Acromioplasty*; and *Pathophysiology and Diagnosis of the "Frozen Shoulder".*

David J Weber has associated with the Green Tree Family Medical Clinic and Family Medicine Associates as a Family Practitioner. He is also currently a clinical assistant professor in the department of family medicine at the University of Tennessee, Memphis.❑

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

Physicians' Recognition Award

Thirteen MSMA members were named recipients of the AMA Physicians Recognition Award in April 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
Raymond F. Grenfell, MD
Robert L. Hotchkiss, MD

Coast Counties Medical Society
David L. Clippinger, MD
Michael J. Gandour, MD
Ben J. Kitchings, MD
E. Duane McClain, MD

East Mississippi Medical Society
Austin P. Boggan, MD

Northeast Mississippi Medical Society
William G. Jackson, MD

South Mississippi Medical Society
John F. Hassell, MD
Joseph E. Johnston, MD
Gathel O. Runnels, MD

South Central Mississippi Medical Society
Ralph L. Brock, MD
James William Pressler, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

Placement Service

Journal MSMA Placement and Classified ads are $2.00/line, with a 4-line minimum charge of $8.00. There are approximately 50-characters per line in 11 point Times Roman type; including each letter, space and all punctuation. Ad copy must be submitted in writing.

Journal MSMA Display Classified ads 1x insertion cost $100.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camera-ready materials are preferred. Typeset ads are available for an additional charge.

Items should be sent to:

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Journal MSMA,
PO Box 5229, Jackson, MS 39296-5229
or Fax to: 601/352-4834

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Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office.

WATS 1-800-962-2230
Jackson, 853-5453
Bill Kindred (Ext.5453)

Disability Determination Services
1-800-962-2230

Family practitioner, BC/BE - Liberty, Mississippi Excellent opportunity for a family physician to practice in a challenging and rewarding rural comprehensive practice where you can make a difference. Salary range of $100,000-$110,000 with excellent fringe benefit package, including malpractice insurance, retirement plan, comprehensive group insurance program, with liberal holiday and leave schedule. The successful applicant may be eligible for a Federal Loan Repayment Program for qualified health professional education loans. This program provides up to $25,000 per year for a two-year commitment and may increase to $35,000 per year for two additional years if a three or four year commitment is made. These funds are in addition to base salary with reimbursement for income tax liability. Contact Pam T. Poole, Amite County Medical Services, Inc., P. O. Box 511, Liberty, MS 39645. (601) 657-4326.

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Dept. of Physician Services
Phone: 800-372-2600
Fax: 305-947-9990

Family Medicine Faculty Position

The Department of Family Medicine at the University of Mississippi Medical Center has openings for two faculty at the rank of assistant professor and above. Responsibilities include direct patient care, clinical teaching, scholarly activities and the opportunity to focus your career on the unique medical education and research programs of the department. Candidates must be board certified in Family Practice.

The Department of Family Medicine at the Mississippi Medical Center was established in 1973. It is a combined university and community program with a family medicine service in the on campus University Hospital and active programs in three large community hospitals. The department has a full-time faculty of 17 with a residency staff of 42. The Mississippi Medical Center is located in Jackson, the state's capitol city. The metropolitan area census is estimated at 400,000.

Contact Hardy B. Woodbridge, M.D., Vice Chairman, Department of Family Medicine, The University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216, telephone (601) 984-5413.

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MSMA
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May 1-5, 1996

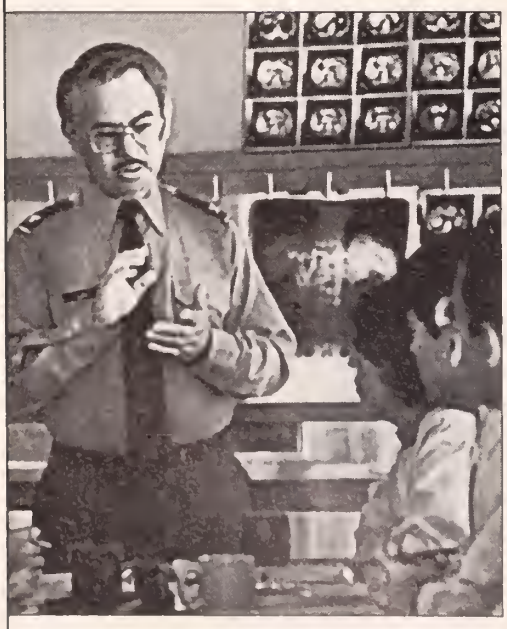
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Kosciusko, Mississippi
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Needs: Full-time

BMH - Union County Hospital
New Albany, Mississippi
153 Bed Facility
Annual ED Visits: 18,000
Needs: Full-time

BMH - North Mississippi
Oxford, Mississippi
150 Bed Facility
Annual ED Visits: 16,500
Needs: Full-time, part-time

Gilmore Memorial Hospital
Amory, Mississippi
95 Bed Facility
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Needs: Full-time, part-time

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Alabama

Walker Regional Medical Center
Jasper, Alabama
267 Bed Facility
Annual ED Visits: 36,000
Needs: Full-time

Jackson County Hospital
Scottsboro, Alabama
170 Bed Facility
Annual ED Visits: 17,000
Needs: Full-time, part-time

Russell Hospital
Alexander City, Alabama
100 Bed Facility
Annual ED Visits: 13,000
Needs: Part-time

Hartselle Medical Center
Hartselle, Alabama
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Annual ED Visits: 9,000
Needs: Full-time

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Executive Director
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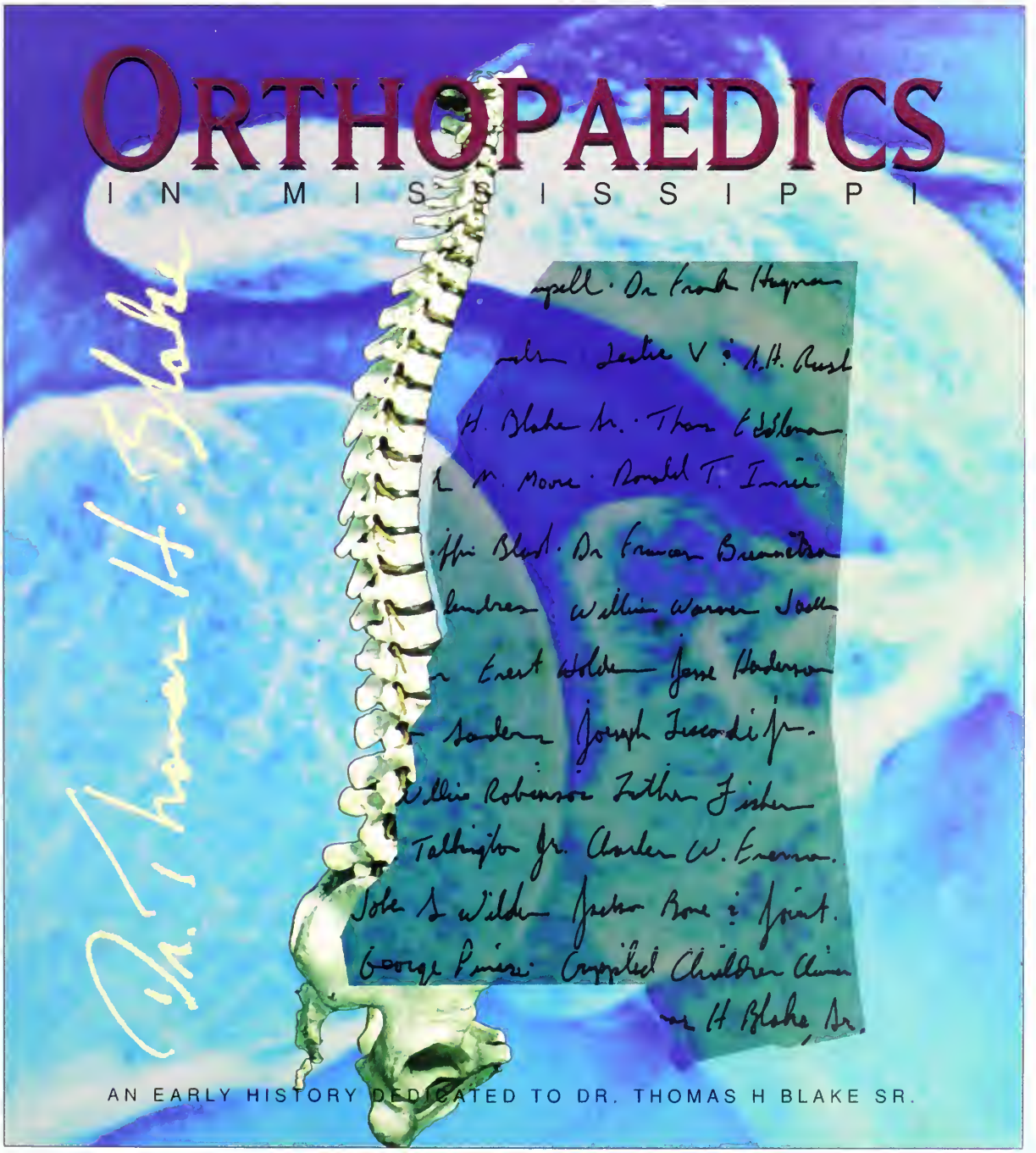
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JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

JULY 1995



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Orthopaedics in Mississippi
-Early History-

George D. Purvis, M.D.

It has been said that in the past more progress has been made in medicine than in all of earlier history. That is certainly true in Mississippi, especially in Orthopaedics as we look at the fifty years 1934-84. Actually, the Mississippi history of orthopaedics may be considered to have begun in 1881 with the birth of Willis C. Campbell.

Born in Jackson, his home was on the corner of North President and Amite Streets. The house later became the convent and nursing dormitory for the first St. Dominic Hospital, the old Jackson Infirmary. Dr. Campbell's birth was significant because he was the founder of the Willis C. Campbell Clinic (WCC) in Memphis, Tennessee and he has been recognized worldwide as a pioneer in orthopaedics. He was one of the small group of founders of the American Academy of Orthopaedic Surgeons. The Campbell Clinic became a leader in training orthopaedic surgeons, the site for training of many members of our Mississippi Orthopaedic Society.

Some time shortly after Dr. Campbell's birth, another early orthopaedist was also born in Jackson. He was Dr. J. Albert Key, who practiced in St. Louis, Missouri. Dr.Key was known for his dynamic, controversial discussion of papers at Academy meetings and for being an author of many papers dealing with orthopaedic subjects. He was coauthor with Dr. Conwell of a book on fracture treatment, a popular reference during the forties and fifties.

Orthopaedics as a specialty did not exist in Mississippi in the nineteen-twenties. Fracture treatment and amputations comprised the majority of cases in what is now recognized as the field of orthopaedics. These procedures were performed by a family type practitioner or the surgeon of that day.

In the early 1930s, Dr. Frank Hagaman, trained in general and orthopaedic surgery at the Hospital for Ruptured and Crippled in New York City (now the Hospital for Special Surgery), joined the Jackson surgical group started by Dr. Harley Shands. In 1939, enroute to Koscuisko to treat a patient with a fractured hip, he was killed instantly in an automobile accident.

Innovation in the treatment of some fractures was introduced in 1936 by fracture surgeons Drs. Leslie V. and H.L. Rush of Meridian. They devised the Rush pin for intramedullary fixation of some fractures, a method still widely used. Their technique required a minimal amount of open approach which was important at that time because the specter of postoperative infection was a major deterrent to open musculoskeletal surgery.

Prior to and into the '50s, about 50% of cases treated by orthopaedists consisted of those treated for infections such as post traumatic, post surgical and tuberculous and in treatment of the effects of poliomyelitis.

Progress in open surgery in orthopaedics was advanced by the introduction of sulfanilamide in 1932. The sulfa drugs facilitated the prevention and control of operative infection, a potential catastrophe. Further advances in the management of infections occurred with the clinical use of penicillin in 1941 and the establishment of the effectiveness of streptomycin treatment of tuberculosis in about 1944. These antibiotics, the evolution of surgical techniques, and the use of the polio vaccines by Salk in 1954 and Sabin in 1960 have practically eradicated the half of orthopaedic practice devoted to infections and poliomyelitis. Now orthopaedic practice is composed almost entirely of cases of trauma or reconstruction.

The first board qualified orthopaedist in Mississippi began practice in Jackson in 1934. He was a native of Alabama, Dr. Thomas (Tom) H. Blake, Sr. After Tom had spent six months studying bone pathology under Dr. Joseph C. Bloodgood at Johns-Hopkins Medical School in Baltimore, Maryland, he received his orthopaedic training at the WCC Clinic in Memphis, Tennessee. In 1937 Tom became the first Mississippi board certified specialist of any kind who had been specialty trained and examined rather than being "grandfathered in." He was in the first group certified by the newly created American Board of Orthopaedic Surgery. Between 1938-45 Tom operated in 81 of the 82 counties in Mississippi. At that time itinerant surgery was not only tolerated but was necessary because of limited transportation and the need for patients to be treated near home.

In 1940, Dr.Thomas S. Eddleman, upon completion of his fellowship at the Campbell Clinic, joined Tom Blake. They formed what was to become the Jackson Bone and Joint Clinic (JB&J). Dr. Eddleman was called into the armed service in World War II but returned in 1946. Also in 1946, Drs. Joseph M. Moore and Donald T. Imre joined different multispecialty groups in Vicksburg, establishing orthopaedics there. Don came from New Orleans where he had been on the staff of the Oschner Clinic with Dr. Guy Caldwell, a leading orthopaedist. Don trained at Charity Hospital in New Orleans and had his children's training in Richmond, Virginia.

Early in the 1940s, the polio epidemics produced such havoc in the lives of many children and adults that Drs. Thomas Blake and Don Imrie spent large segments of their time in treating those in the acute and paralytic stages of the disease. In Jackson that treatment was performed in World War II type barracks on the grounds of the Mississippi State Insane Asylumn, now the site of the University of Mississippi Medical Center (UMC) in Jackson.

Dr. Griffin Bland, after finishing a year of surgery in Memphis in 1946, came to assist Dr.Tom Blake and others in work at the polio hospital. He recalls that they had a census of about 112 patients in the hospital at a time and had twelve respirators. The respirators had only hand operated pumps for emergency use in case of power failure. After that experience treating polio, Griffin went to the Campbell Clinic for training in orthopaedics rather than pursuing training in neurosurgery as he had previously intended doing. In 1951 he initiated speciality practice of orthopaedics on the Gulf coast in Gulfport.

Orthopaedic training in Mississippi was initiated by Dr. Blake in 1943 when he started a board approved one year residency in Children's Orthopaedics at the Mississippi Baptist Hospital in Jackson. The first resident was a woman, Dr. Frances Brenneka. An international flavor was added by the training of a San Salvadorian native, Dr. Colendres. Subsequently, many of the older generation of Mississippi orthopaedists rotated through that program. Some of those are Drs.William C. Warner, Sr. (1948-49), Jack H. Phillips (1953), Ernest Jeff Holder (1956-57), Jesse L. Henderson 1956-57), William C. Sanders (1961-62), Joseph P. Licciardi, Jr. (1961), McWillie M. Robinson (1960-64), Luther C. Fisher (1963), T. W. Talkington, Jr. (1963-65), Charles W. Emerson (1964-66) and S. Jobe Wilder (1965).

The majority of Mississippi orthopaedists have been trained in Memphis, New Orleans or Jackson. There have been enough trained in other centers to supply leavening. Originally, orthopaedic training was considered as something to be supplied by the institution in return for services rendered by the trainee. The first of us who trained at the Campbell Clinic were supplied room and board on the clinic premises and fifty dollars per month. That led us to place little value on our time or talents. We were given no instruction in the economic aspect of our profession but were taught that we were a part of a service profession. The patient and his or her welfare was of prime importance.

In July of 1949 upon completion of his year in the Baptist Hospital program, Bill Warner, Sr. joined Tom Blake and Tom Eddleman at the Jackson Bone

and Joint Clinic. Bill had completed his other training at the Veterans Administration Hospital in Memphis under the tutorship of Dr. Dana Street who is known for development of the Street intramedullary nail for the femur.

Dr. John G. Caden, Jr., a University of Alabama graduate and Willis C. Campbell Clinic fellow, joined the Jackson Bone and Joint Clinic in 1954. Within the ensuing year John was called into military service and afterward returned to the staff of JB&J Clinic in 1957. Louis A. Farber and McWillie M. Robinson in '64, L. Buford Yerger, Jr. and X. Clyde Copeland, Jr. in '66, Kendall T. Blake and Ward T. McCraney in '79 joined the JB&J Clinic.

In February 1950, George Purvis , also a Willis C. Campbell Clinic fellow, entered solo practice in Jackson. He cooperated with the Jackson Bone & Joint Clinic doctors in supplying staffing for the Charity Hospital, the Mississippi Crippled Children's program, the Mental Hospital at Whitfield and the Vocational Rehabilitation Service. Crippled Children Clinics were developed in various areas of the state after the program began in 1936. In the '40s and '50s, Dr.Tom Blake, his associates and George traveled to Grenada, Greenville, Greenwood, Columbus, McComb, Hattiesburg, Laurel and other sites. The Campbell Clinic in Memphis served clinics in Tupelo, Clarksdale and other northern areas and Dr. W.C. Hannon from Mobile served the Mississippi coast area. Those clinics were held about every two weeks and required driving a nurse and a brace man 100 to 150 miles before an eight o'clock clinic, seeing sixty to 100 patients, returning home to make rounds, see consultations and new patients and arrange surgery for the next day. The surgeons then performed up to six to eight major operations on crippled children every week.

My experiences in the Charity Hospital in Jackson from 1950 until 1955, when the University Hospital opened and Charity Hospital Closed, demonstrate the primitive state of some surgery in Mississippi at that time. The Charity Hospital major operating room was a room about twelve feet square. Directly over the operating table was a clear glass skylight. There was no air-conditioning. In summer the windows were open; there was one oscillating fan. Unless the surgeon was able to persuade the anesthesiologist or a nurse anesthetist to help him, he did surgery under local anesthesia or under spinal anesthesia which he administered. Those patients were observed by Pearly, an obese, elderly orderly who watched them and occasionally took their blood pressure!

Until the '60s and '70s emergency room coverage was supplied by the staff physician on call for each division. There were no emergency room physicians then. Routinely the nurse in the emergency room contacted the orthopaedist on call when a patient appeared with something pertaining to the neck, back or extremities. That meant we were called for sprains, contusions and even minor lacerations for those areas in addition to those who had true orthopaedic problems. The early orthopaedist expected to work twelve to sixteen or more hours per day. An example is offered by an office employee of Dr. Blake's who began working for him in the '30s. She recalls that the first day at work, she found patients queued up at the reception desk in a long line before 8:00 a.m. and they sat and waited until Dr. Blake came in. He operated all day that day, arrived at the office at 7:00 p.m. and they finished office hours at 11:00 p.m. She says, "I thought, what am I getting into?" Others remember frequent similar days in practice when they finished seeing patients in the office at 9:00 p.m. or later.

Drs. Thomas C. Turner in 1955, William B;, Thompson in '63, James 0. Manning in '65, and later Drs. Guy T. Vise, Jr., George W. Truett, Walter R. Shelton and John M. Purvis joined George Purvis and practiced as the Central Orthopaedic Clinic. After one year Dr. Vise left to become full-time director of the Mississippi Methodist Rehabilitation Hospital. In '84, Drs. Manning and Shelton withdrew and formed the Mississippi Sports Medicine and Orthopaedic Center. They have been joined by Drs. Gene R. Barrett and Felix N. (Buddy) Savoie, III. Practitioners of orthopaedics in Jackson rapidly increased as Drs. Elmer J. Nix in '63, Bobby Gene Spell in '65, T. W. Talkington, Jr. in '66 and Edward T. (Tommy) James, Jr. in '76 entered solo practices. Dr. Jobe Wilder joined Dr.Tom Talkington in 1969 and Dr. Sidney R. Berry joined Dr. Nix in 1970. Dr. Nix and Dr. Berry formed the Mississippi Spine Clinic. Dr. Charles W. Emerson, an orthopaedic hand surgeon who trained at MBH and Vanderbilt University, began Jackson practice at the Mississippi Methodist Rehabilitation Hospital in the '70s. Other hand surgeons, Chris P. Ethridge and Alan E. Freeland, arrived later. Dr. J. Patrick Barrett, in the late '70s began practice with special interest in spine surgery and has been joined by Dr. E. Greg Wood, III. Drs. Van H. Temple in 1976 and David J. Gandy in '82 were associated with Drs. Nix and Berry until they withdrew and formed what is now the Capital Orthopaedic Clinic. Currently there about forty orthopaedic surgeons listed in the Jackson area.

For a few months in the early fifties Dr. David G.

Vesely, who had his training at the V. A. and St. Joseph Hospitals in Memphis, practiced in Greenwood. However, he was called into military service in the Korean conflict. When released, he joined Dr. Sherrill in Birmingham. Dave is remembered as co-developer of the Vesely-Street split-tailed intramedullary nail and as president of the Alabama Orthopaedic Society 1954-55. He died in 1988.

As stated above, Orthopaedics arrived on the Mississippi Coast in July 1951 when Dr. Griffin Bland began practice in Gulfport. Dr. W. C. Hannon of Mobile was pleased to turn over his Mississippi Crippled Children work to Griffin who continued active in the program for forty years when he retired in 1992. Ed Troop entered the practice of orthopaedics on the coast at about the same time as Griffin. Dr. Bland was joined in practice by Dr. Magruder S. Corban. Mack continues practice along with Dr.Craig M. Slater. Dr. Daniel J. Enger led in the eastward spread of orthopaedists on the coast when he left the military service in 1961 and began practice in Pascagoula. He died in February 1994. Dan's obituary indicated that in his thirty-two years of practice in Pascagoula he had treated more than 65,000 patients. It is said that early on he served as orthopaedist, neurologist and neurosurgeon in his area. There are currently sixteen orthopaedists in the Mississippi coastal area.

Orthopaedic Surgery was pioneered in Hattiesburg in 1952 by Dr. Francis R. Conn. Francis, a Tulane graduate, served two years as a flight surgeon after his internship at Charity Hospital in New Orleans. He then returned to Charity for his orthopaedic residency before he went to Hattiesburg. Dr. Ed Attix went into practice in Hattiesburg in about '56 and was followed by Gary Giles. There are now nine orthopaedists listed as certified by the American Board of Orthopaedic Surgery practicing in Hattiesburg.

Greenville had its first Board certified Orthopaedist in 1952 when Dr. Herman N. Hamilton opened his office there. Dr. Myron Z. Neal practiced in Greenville before transferring to the Veterans Administration Hospital in Jackson. Dr. Berry and later Dr. Merbitz did orthopaedic treatment at the Gambel Brothers Clinic in Greenville.

The first Orthopaedist in Laurel was Dr.James C. Bass who arrived in 1955. Jimmy did his orthopaedic residency at Georgetown University in Washington, D. C. He was active in the treatment of polio patients at the South Mississippi State Hospital, in Laurel, and had a clinic named for him at that facility in later years. Jimmy died in 1977. He had been joined in practice by Dr.E. Jeff Holder in 1960. Subsequently, the Laurel Bone and Joint Clinic, which they formed has added four other orthopaedists: Drs. Cleveland E. Johnson, Thomas H. Blake, Jr., Edward R. Turnbutt, and John J. McGraw.

The University of Mississippi Medical School was moved from Oxford and changed from a two year to a four year institution in 1955. From the beginnning, Orthopaedic Surgery was a Division of the Surgery Department. Dr. Thomas Blake, Sr. was the first Director of the Division. He served on a part-time basis assisted by other clinicians in the area. In September of 1955, Dr. William F. Enneking was named full-time Director of the Division of Orthopaedic Surgery at the University. Bill had just completed his residency in Chicago under Dr. Hatcher, an authority in bone pathology. Dr. Enneking promoted development of the orthopaedic residency program, established research programs, wrote and spoke frequently. In December 1959, Dr. Enneking resigned from the University Medical Center, primarily because of inability to achieve Departmental status for his Division. Bill's impact on orthopaedics in Mississippi was so great that all clinical orthopaedic staff physicians in Mississippi resigned in support of his stance.

Dr. Enneking recently reminisced about those years at the University. He remembers that the first orthopaedic resident was Dr. Calvin Frazier who now practices in San Jose, California. The second was Dr. William Seigrest, now deceased. The next two were Drs. Bob Field and Skip Copeland. Both transferred to the University of Florida with Dr. Enneking when he went there on leaving the University of Mississippi Medical Center. Dr. Field practices in Orlando, Florida. Skip Copeland practices in Jackson with the Jackson Bone and Joint Clinic. Drs. Bill Thompson and Louis Farber had just begun their residency when Dr. Enneking left. They remained at the University of Mississippi Medical Center and completed their residencies. Then Dr.Bill Thompson joined the Central Orthopaedic Clinic in Jackson. He now practices with George Truett in River Oaks Tower in Jackson. Dr.Lou Farber joined the Jackson Bone and Joint Clinic in Jackson. Lou died in 1993.

Bill Sanders had his first year with Dr. Enneking and transferred to the Mississippi Baptist Hospital program to complete his training. He entered practice in Columbus, Mississippi in 1962.

There was a hiatus at the University of Mississippi Medical Center while the Division was headed by Dr. James Hardy, Professor of Surgery, and Dr. Gus

Neely, Assistant Professor of Surgery. Dr. Paul S. Derian was named Director of the Orthopaedic Division in later 1960. Dr. William Frank Owens, Jr. who had been in private practice in Tuscaloosa, Alabama joined the University staff. University residents remember Dr. Owens as an excellent teacher who gave them much insight into the intricacies of orthopaedic practice. Frank returned to Alabama in 1972 and entered practice in Birmingham.

On finishing his training at UMC in 1970, Dr. E. Frazier Ward entered the United States Air Force. He returned to the University in 1972 and was named an Assistant Professor of Orthopaedics. In 1973, George Wharton was added as an Assistant Professor.

In his annual 1975-76 report to the Chancellor of the University of Mississippi Medical Center, Dr. James Hardy, Professor of the Department of Surgery, stated, "Dr. Paul S. Derian, Chairman of the Division of Orthopedic Surgery, elected to step down as chairman and Dr. E. Frazier Ward was appointed Acting Director of the Division. A search committee is actively working to recruit a permanent Chairman of Orthopedic Surgery." Dr. Ward held that position from September 1976 until January 1977.

To their credit, eleven resident staff members of the Orthopaedic Surgery Division at the University of Mississippi Medical Center were dismissed because of their stand in protest to matters which led to Dr. Derian's "stepping down." However, all of those who wished, with the support of orthopaedists throughout Mississippi, were able to continue their training in other excellent centers throughout the nation.

Dr. James L. Hughes, Jr. moved from the Orthopaedic Surgery Department of Johns-Hopkins Hospital to become Director of the Division of Orthopaedics at the University of Mississippi Medical Center in 1977. Ten years later on Januarv 1, 1987 under Hughes' direction, the Division of Orthopaedics was designated as the Department of Orthopaedic Surgery at the University of Mississippi Medical Center. The orthopaedic resident staff of the UMC fluctuated from four to thirteen in the years 1975 to 1980. There have been fifteen residents yearly from 1980 to the present. The Department now has five divisions and ten faculty staff physicians.

Tupelo had its first orthopaedist in 1961 when Dr. Houston Franks who trained at University of Mississippi Medical Center established his practice in Tupelo. He was followed by Dr.Tom Purser, from 1968 to '73. Drs. Earl E. Whitwell (1973), Ben H. Buchanan (1974) and F. Mitchell Massey (1975), all trained at the University of Mississippi, arrived in Tupelo in rapid succession. Now there are three other orthopaedists listed in that community.

In 1975 Dr.Wiley C. Hutchins left the staff of the Campbell Clinic and opened practice in Columbus where Dr. Bill Sanders had started orthopaedics. Wiley was joined later by Dr. Charles S. Rae, Jr., a product of University of Mississippi, training. They were recently joined by Dr. Russell C. Litton, a Campbell Clinic fellow.

Meridian's orthopaedic talent expanded with the arrival of Dr. Donald E. Cook in 1968 and then the additional orthopaedists: Drs.Thomas D. Little, Johnny Robinson, James R. Green and later, four others. Dr. Little indicates that he did the first total hip arthroplasty in Mississippi in 1971. The first clean air operating room was opened in Jackson in 1972 and a total hip arthroplasty program was initiated at Baptist and St. Dominic Hospitals then.

Natchez saw the arrival of orthopaedists in 1954 when Dr. Jack Phillips, a graduate of the Mississippi Baptist Hospital program, went there. He was followed by Drs. John C. Passman, Eugene E. Taylor, Jesse L. Henderson and R. T. Van Uden.

Dr. Wayne T. Lamar brought our specialty to Oxford in 1973. Also in 1973, Dr. Edward Hemmes initiated the practice of orthopaedics in Clarksdale. When he retired in 1985, Dr. William Barr entered practice in Clarksdale.

Dr. John G. Gassaway, in 1974, was the first orthopaedic surgeon in Starkville. He was followed by Dr. Martin M. Pomphrey, Jr. John added part-time practice in West Point in 1981 and moved his full practice there in 1985.

Orthopaedic practice was reopened in Greenwood in 1976 by a native son, Dr. Fred M. Sandifer, III. Two other orthopaedists have more recently entered practice in Greenwood.

In the '70s and later, four other orthopaedists, Drs. Daniel P. Dear, William C. Porter, III, David M. Thompson and Wallace W. Weatherly have succeeded Dr. Don Imrie and Dr. Joe Moore in Vicksburg.

The Mississippi Orthopaedic Society was organized in 1958 when several of us met in the old LeFleur's Restaurant on South President Street. We were joined by Dr. Earl McBride of Oklahoma City, the founder of the McBride Clinic there and the author of a still familiar book on disability evaluation. McBride had been invited to the meeting by Dr. Blake because of Dr. McBride's experience assisting in the formation of the Oklahoma Orthopaedic Society. He encouraged us to organize a Mississippi Society. We agreed to draw up a constitution and by-laws and

proceeded with foundation of the Mississippi Orthopaedic Society. The constitution and by-laws have subsequently been revised in 1987 and again in 1991.

In honor of Dr. Tom Blake, Sr. the Mississippi Crippled Children Clinic was renamed the Blake Clinic for Children in 1982. Tom had worked with the Mississippi Crippled Children's Service from its inception in 1936 until 1982. Part of that time he served as the medical director of the program. Tom retired from practice in 1977. He died in June 1992 and was buried on his eighty-eighth birthday.

This paper is dedicated to the memory of "The Father of Orthopaedics in Mississippi," Dr. Thomas H. Blake, Sr. Using the principles of integrity, diligence and excellence Tom Blake demonstrated basic characteristics which have been incorporated in orthopaedic practice, in Mississippi. We are indebted to him for that heritage.

Presented by ***George D. Purvis, M.D.*** *at the annual meeting of the Mississippi Orthopaedic Society, Old Waverly Golf & Country Club, West Point, MS, April 17, 1994.*

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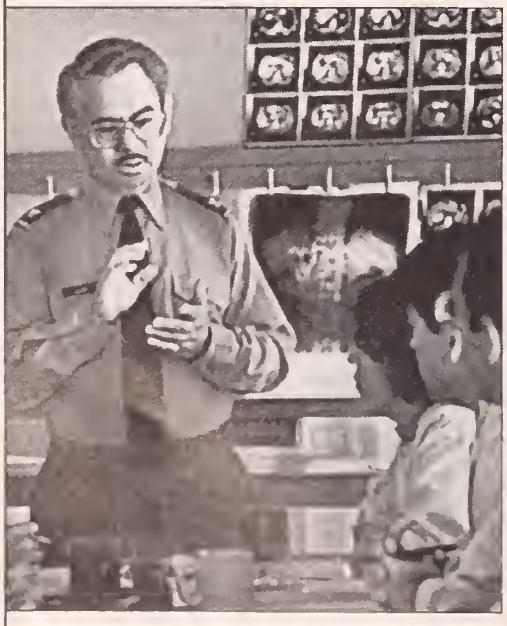
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Managing Diabetic Retinopathy: The Partnership Between Ophthalmologist and Primary Care Physician

Ching J. Chen, MD
Joel Herring, BA
Alice S. Chen

ABSTRACT

Diabetic retinopathy (DR), an ocular complication of diabetes mellitus, is the leading cause of blindness in Americans age 20 to 74 today. The more severe stage of the disease, proliferative diabetic retinopathy, affects an estimated 700,000 Americans. Based on clinical findings, the disease is generally classified as nonproliferative DR or proliferative DR. While the former often begins as a symptomatically silent disease, it nevertheless may be progressing to itself cause significant visual loss. Based principally on evidence from several studies sponsored by the National Eye Institute, current treatment consists of regular observation by an ophthalmologist, laser photocoagulation, and vitrectomy. In addition, preventive methods such as tight glycemic control and ophthalmic screening of diabetics appear beneficial. While the ophthalmologist can provide specialized services for the DR patient, prevention and control lie largely in the hands of the primary care physician. Thus, only when primary and specialized care have established a strong partnership can they save the sight of the thousands at risk for diabetic retinopathy.

KEY WORDS: **Clinical Trials**
Diabetic Retinopathy
***Diabetic Retinopathy/ec**
***Diabetic Retinopathy/pc**
***Diabetic Retinopathy/pp**
Light Coagulation
Vision Screening/st

INTRODUCTION

In 1955, E. Jaeger published a paper describing a case involving a 22-year old patient complaining of "sparks, cloudiness, and blurred vision." Along with his description, he included a color drawing of the patient's right eye showing a swollen optic disk, an unnaturally red retina marked with blood-colored spots and irregular, bright yellow areas, and darker, twisted retinal veins. With this drawing, diabetic retinopathy first appeared in the annals of ophthalmological history.[1]

Today, almost 150 years later, diabetic retinopathy (DR) is the leading cause of blindness among Americans age 20 to 74 years.[2] Most patients with DR have had diabetes for 10 to 15 years; the retinopathy can cause visual loss, blue-yellow vision defects, and decreased contrast sensitivity.[3] In addition, the more severe stage of the disease, proliferative diabetic retinopathy (PDR), affects 700,000 Americans with 65,000 new cases yearly. This represents a substantial cross-section of the primary care patient population. Furthermore, over half of the cases of DR threatening visual loss are not treated, thus resulting in potentially drastic effects and eventually greater expense to the patient and the health care system.[2]

PATHOPHYSIOLOGY AND CLASSIFICATION

Diabetic retinopathy is a highly specific vascular complication of chronic diabetes mellitus. The disease begins with slowly progressing retinal ischemia, capillary nonperfusion in the form of infarcts and arteriolar obstructions, and it culminates in severe cases with retinal neovascularization, detachment, and

blindness.[3]

A definite pathogenesis for DR has yet to be established. However, a possible genetic basis exists in correlation with certain HLA antigens.[4] In addition, the progress rate of DR increases in cases of systemic hypertension and pregnancy among diabetic women.[5] Generally, DR is classified in two categories based on signs of progressive disease: nonproliferative (NPDR) and proliferative (PDR). Within these two general categories are several subclasses based on a spectrum of clinical findings. These can be summed up as follows:

A. Nonproliferative DR

1. "Mild"--microaneurysms, localized hemorrhages, hard yellow exudates, macular edema (Fig. 1)

2. "Moderate"--cotton wool spots, extensive retinal hemorrhages, venous beading, intraretinal microvascular abnormalities (IRMA)

3. "Severe" (also "Preproliferative")--increasing incidence and extent of the above (Fig 2)

B. Proliferative DR

1. Fibrovascular stage--neovascularization of the disk and retina, arborization into vitreous with collagen fibrils

2. Contraction stage--vitreous shrinking causing vitreous hemorrhage, tractional retinal detachment, loss of vision.[2,6] (Fig 3)

Clinically, the signs of NPDR are harbingers of retinal vascular occlusion. The resulting ischemia is thought to prompt the proliferation of new vessels and fibrous tissue. When this neovascularization enters into the vitreous space, the patient is considered to have PDR.[3,6]

A disproportion may exist between a patient's symptomatic complaints and the clinical signs of advancing disease. In the nonproliferative stage, patients may maintain good visual acuity in the midst of silently progressing retinopathy. Proliferative stage DR, in contrast, can be marked by serious, and sometimes sudden, loss of vision.

Severe visual loss in eyes with PDR can result from several processes. First, vitreous hemorrhages from preretinal neovascularization can interfere with retinal function. Second, the fibrous tissue itself may form an epiretinal membrane, similarly obscuring the retina from light penetration. Finally, contraction of the neovascularized vitreous can result in wrinkling of the now- attached retina. This causes macular displacement or detachment and accompanying blindness.[6]

Finally, it should be noted that the signs of severe NPDR may appear to diminish in the period before new vessels develop. This false improvement can mask the

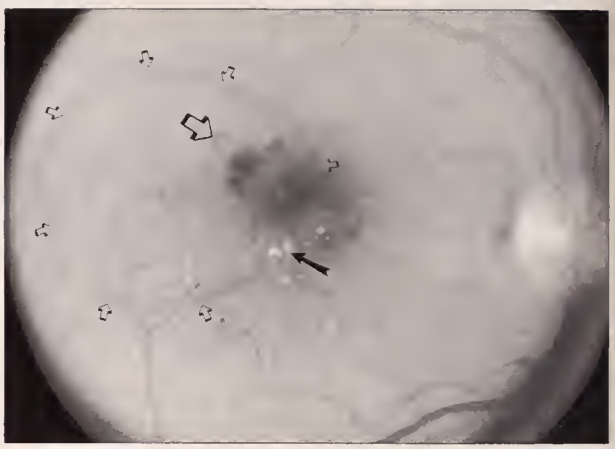


Figure 1. Mild nonproliferative diabetic retinopathy with microaneurysms (open arrow), hard exudate (closed arrow), and area of macular edema (surrounded by small arrows).

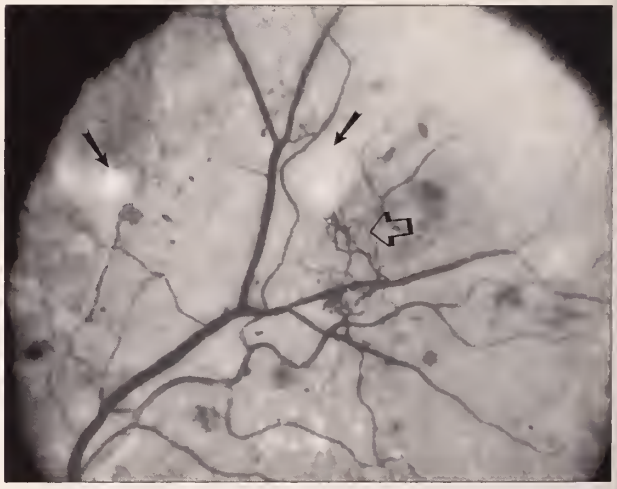


Figure 2. Severe nonproliferative diabetic retinopathy (or preproliferative diabetic retinopathy) with cotton wool spots (closed arrows) and intraretinal microangiopathy (open arrow).



Figure 3. Contrection stage of proliferative diabetic retinopathy with severe fibrovascular proliferative tissue and tractional retinal detachment.

more ominous risks of PDR which follow.[6] Because of the disappearance" of signs that sometimes precedes development into full-blown PDR and because of the asymptomatic nature of some cases of NPDR, a familiarity with the progression of DR is imperative in preventing blindness.

CLINICAL DIAGNOSIS

Current techniques for detecting and diagnosis diabetic retinopathy include direct ophthalmoscopy through non-dilated pupils, indirect ophthalmoscopy, biomicroscopy through a condensing contact or noncontact lens, stereoscopic fundus photography through dilated pupils, and fluorescein angiography. Nonmydriatic photography is also being considered as screening option for DR.[7]

Of the ophthalmoscopic techniques, biomicroscopy offers the advantage of better resolution, while indirect ophthalmoscopy allows the examiner view of the more peripheral regions of the retina. On the other hand, to the primary care physician, perhaps the most important of these scopes is the one to which he or she has the readiest access--the direct ophthalmoscope.

Of all these diagnostic techniques, however, the most accurate is probably the fluorescein angiography, often used as standard in assessing other screening techniques. Introduced in 1961, this technique involves the injection of sodium fluorescein into the antecubital vein and the subsequent recording of results photographically on black and white film at 0.6-0.8 second intervals. As the fluorescein-blood mixture enters the retinal and choroidal circulation, abnormalities of the retinal circulation can be visualized by tracing the fluorescence.

The usefulness of this technique in diagnosing diabetic retinopathy is patent. For example, in NPDR cases, fluorescein angiography offers the following advantages to ophthalmoscopic and/or ordinary photographic techniques: It can differentiate microaneurysms from hemorrhages (fig 4), it can clearly identify areas of capillary nonperfusion (Fig 5), it can assess more accurately the severity of any macular edema present (Fig 6), and it can verify the degree of stagnation of the vascular flow. Meanwhile, in cases of PDR, fluorescein angiography can indicate the presence of small areas of neovascularization either on the optic disk (NVD) or elsewhere (NVE) (Fig 5), dramatize the existence of preretinal hemorrhage (Fig 6), and detect structural changes such as tractional pulling on the retinal surface.[8]

With the correct evaluation of fluorescein angiograms or other modes of diagnosis, one can move



Figure 4. Fluorescein angiography showing microaneurysms with fluorescein dye filling.

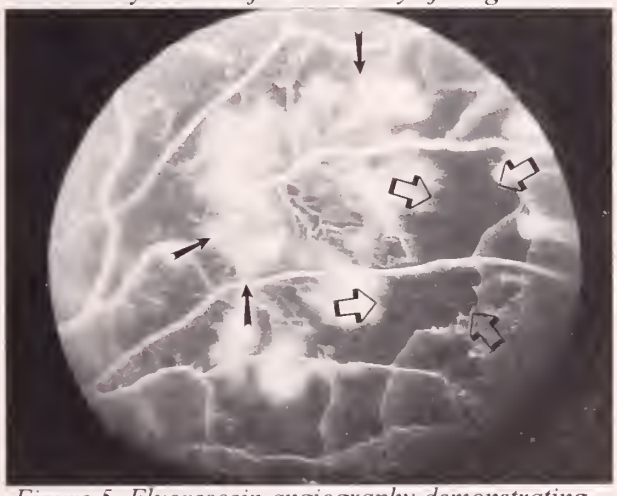


Figure 5. Fluorescein angiography demonstrating area of capillary nonperfusion (surrounded by open arrows) and retinal surface neovascularization (closed arrow) with dye leakage in proliferative diabetic retinopathy.



Fig. 6. Fluorescein angiography demonstrating macular edema with fluorescein dye leakage in nonproliferative diabetic retinopathy (closed arrow).

leakage in nonproliferative diabetic retinopathy (closed arrow).



Figure 7. Fluoroscein angiography showing a blockage of dye by preretinal hemorrhage (open arrow) in proliferative diabetic retinopathy.

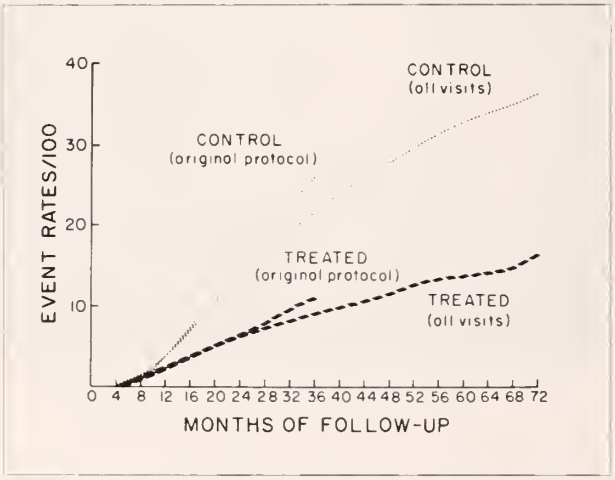


Figure 8. DRS Report. The above figure shows the efficacy of panretinalphotocoagulation in preventing severe visual loss (defined as acuity worse than 5/200). The Diabetic Retinopathy Study began with 1758 PDR patients who each had one eye randomly assigned to receive photocoagulation treatment and the other eye assigned to serve as control. After two years, the partial results from the eyes studied prompted the DRS to change its protocol to allow treatment for all high-risk eyes (more advanced PDR); thus, some eyes originally assigned to serve as controls later received treatment. Calculated cumulative rates of severe visual loss are shown for treated and control groups, both before and after the protocol change. Also, groups treated with argon and xenon lasers are shown together. [Reprinted with permission from Ophthalmology. 1981; 88:683-600.]

on the appropriate therapeutic steps.

STUDY REVIEWS AND TREATMENT

Current modalities of care for DR consist of regular observation by an ophthalmologist, laser photocoagulation, and possible vitrectomy. In the future, alternatives to laser surgery might lie in preventive procedures. For example, the administration of aminoguanidine, aldose reductase inhibitors, and ticlopidine had all been shown to prevent or inhibit the development of experimental DR in laboratory animals.[9,10,11] All the above are, of course, part of a therapeutic alliance with preventive measures of controlled diet and glucose levels, exercise, and insulin management.

I. At this time, the most widely-used form of treatment lies in laser photocoagulation with either an argon blue-green beam or light of another wavelength. In this mode of treatment, the ophthalmologist uses intense beams of light to seal off the proliferative neovascular blood vessels within the eye or to "dry up" areas of exudative leakage. Furthermore, the laser can also be used to destroy portions of ischemic retina, stopping the release of the vasoproliferative growth factor that triggers neovascularization. This destruction of ischemic retina, in turn causes retinal thinning due to a scarring process; the thinning apparently relieves hypoxia and thus inhibits the progression of PDR. Often, repeated laser application is necessary to affect regression of neovascularization.[12]

Investigators first began to use the laser in treating diabetic retinopathy in the early 1960's. At the time, several techniques of laser photocoagulation were developed. To determine the best method for treating diabetic retinopathy with the laser, the National Eye Institute sponsored a series of clinical trials beginning in 1972. The first of these trials was called the Diabetic Retinopathy Study (DRS). It was from the results of the'DRS and its outgrowth studies that most of the guidelines for laser treatment today were established.[12]

The Diabetic Retinopathy Study (DRS), a randomized, controlled clinical trial consisting of 1758 participants, supported the use of panretinal photocoagulation in treating DR patients. This type of photocoagulation involves the scattered application of between 800 and 1600 round, 500 micron spots on the retinal surface, avoiding areas around the optic nerve and central macula. Basically, the DRS found that panretinal photocoagulation reduced the incidence of severe visual loss by 50% among high-risk patients--high-risk patients being defined as having more

advanced PDR. For those without high risk retinopathy (those patients with early proliferative or NPDR), immediate photocoagulation showed no clear benefit over deferral of treatment with follow-up. In addition, the DRS found that argon laser photocoagulation resulted in fewer side effects than similar treatment with a xenon beam.[2] (Fig 8)

The question of when to apply laser treatment was further pursued in the Early Treatment Diabetic Retinopathy Study (ETDRS). In following 1490 eyes not exhibiting high-risk characteristics, the ETDRS made a distinction between patients with and without clinically significant macular edema. Focal photocoagulation appeared to especially benefit those with macular edema. In all eyes studied, however, the risk of severe visual loss was very small: 2.5% in treated eyes and 4% in deferred. Furthermore, among patients on aspirin therapy for cardiovascular or other medical indications, the study demonstrated no beneficial or adverse effects of the aspirin on DR.[2] (Fig 9)

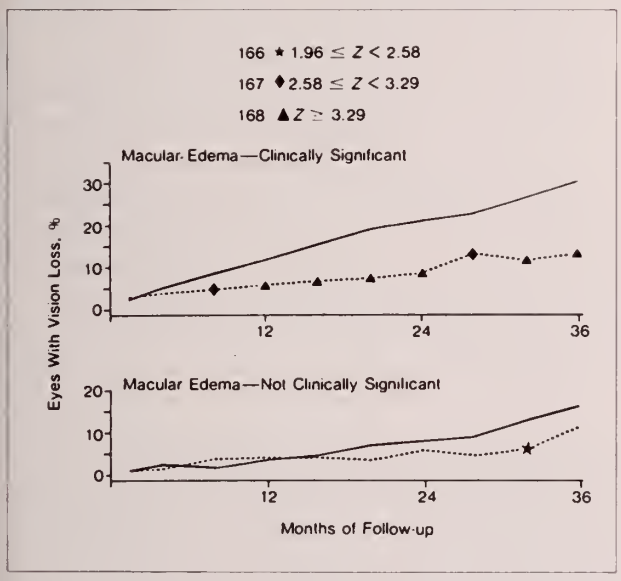


Figure 9. ETDRS Report. The two figures show the effect of early photocoagulation on less-than-high risk DR patients with and without significant macular edema. Significant macular edema is defined by the following characteristics: thickening of the retina, or >1 disk diameter-sized zones of retinal thickening within one disk diameter of the macular center. Vision loss is defined as at least doubling of the visual angle. Early treatment appeared to especially benefit patients with significant macular edema. [Reprinted with permission from Arch Ophthalmol. 1985; 103: 1796-1806.]

II. The alternative of vitrectomy--the removal of the vitreous gel from the posterior chamber of the eye--in managing PDR was also explored, most notably in the Diabetic Retinopathy Vitrectomy Study (DRVS). At the time the DRVS was initiated, vitrectomy was usually reserved for eyes with severe vitreous hemorrhage of over one year's duration. This was due to the high rate of complications accompanying the relatively new procedure. Since long-standing vitreous hemorrhage appeared to damage the retina and/or stimulate the formation and contraction of epiretinal membranes, the DRVS attempted to determine whether earlier vitrectomy would be more useful in the treatment of DR. The DRVS followed treatment of 622 diabetic patients with recent vitreous hemorrhage, comparing the results of performing early vitrectomies to the results of deferring the surgery for one years. In Type I diabetic patients, early vitrectomy appeared to increase the chance of maintaining good vision, while no such benefit was found in Type II patients. In addition, the DRVS recommended early vitrectomy in eyes with more advanced PDR.[2,13,14] (Fig 10)

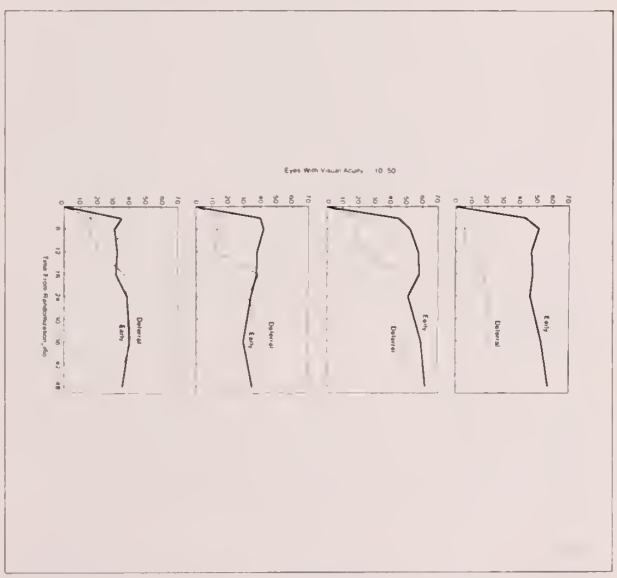


Figure 10. DRVS Report. The four graphs depict, from top to bottom, the effect of early vitrectomy (as opposed to deferral) on patients with Type I diabetes of fewer than 20 years, patients with Type I diabetes of more than 20 years, patients of mixed diabetes type,and patients with Type II diabetes. Early vitrectomy improved the chances of maintaining good vision in Type I patients; this result was not observed in Type II patients. [Reprinted with permission from Arch. Ophthalmol. 1990; 108:961.]

III. In addition to surgical means, tighter glycemic control has been shown to inhibit the progression of DR. In 1993, the Diabetes Control and Complications Trial Research group (DCCT) published a report to this effect. The DCCT followed 1,441 patients with IDDM (726 with no DR, 715 with mild DR) for a mean of 6.5 years. These patients were randomly assigned to either intensive therapy (via insulin pump or 3+ daily insulin injections) or conventional therapy (via 2 daily insulin injections), with the onset and progression of DR assessed regularly. In both the patients who began with no DR and those who began with mild DR, intensive therapy reduced the adjusted mean risk of disease development or progression.[15] (Fig 11)

IV. Furthermore, regular screening of the diabetic population via ophthalmoscopic examination and/or nonmydriatic photography could help to prevent or control the disease. In fact, at least 50%, of blindness from diabetes mellitus could be prevented by laser surgery in eyes diagnosed in time. Given the possibility for prevention, the American Academy of Ophthalmology recommends that patients age 10-30 with a diabetes diagnosis of 5 years' duration should have a baseline eye exam with ophthalmoscopic examination through dilated pupils. In addition, patients older than age 30 should have a baseline exam at the time of diabetes diagnosis. Follow-up ophthalmic exams should continue annually, with frequency increased should this be indicated by the presence of abnormalities or should the patient undergo pregnancy. The American Diabetes Associations's recommendations for screening are much the same.[7]

Finally, not only could screening save vision in thousands of eyes, but the procedure also appears to be cost-effective. At least four models testing the cost-effectiveness of screening for DR have been set up, two in the United Kingdom and two in the United States. According to both the British and American models, screening among patients with Type I diabetes more than paid for itself in the disability payments saved by blindness prevented. Furthermore, in Type II diabetes patients, the models also predicted that screening could efficiently provide additional sight-years.[7,16]

THE ROLE OF PRIMARY CARE PHYSICIAN

Diabetes mellitus affects an estimated 12 million Americans today. The disease has far-reaching complications involving numerous body systems, with substantial risk for morbidity and morality. In Mississippi alone, the Centers for Disease Control have

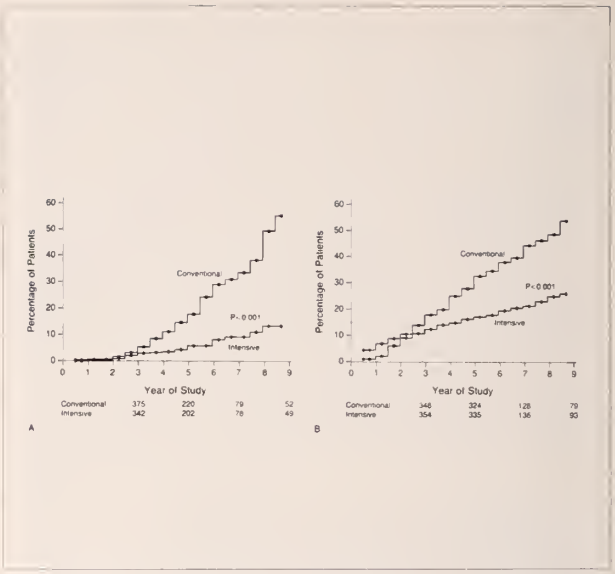


Fig 11. DCCT Study Report. The two figures above show the cumulative incidence of a sustained change in retinopathy in Type I diabetic patients receiving either conventional or intensive therapy. A sustained change in retinopathy is defined as change observed by fundus photography and sustained for >6 months of >3 steps from baseline. Conventional therapy consisted of 1-2 daily insulin injections, while intensive therapy consisted of use of an insulin pump or 3+ daily insulin injections. Intensive glycemic control reduced adjusted mean risk of the onset of retinopathy by 76% (as compared with conventional control) [Reprinted with permission from N Engl J Med. 1993; 329:977-985.]

estimated over 164,000 cases of diabetes, at an estimated state cost of $244 million per year in medical and loss-of-productivity costs. Furthermore, diabetes-related complications affect more than 825 Mississippians annually with over 170 new cases of blindness per year--half of which can be prevented by time laser surgery.[17,18]

What can the primary care physician do? To answer this question, the American Academy of Ophthalmology has established a program for eliminating preventable blindness called Diabetes 2000, which includes recommendations for the primary care physician. Both office practices and referral guidelines are highlighted. In the office, primary care physicians are encouraged to enhance funduscopic skills and recognition of the stages of diabetic retinopathy by examining the retina regularly through dilated pupils. Indeed, studies have shown the efficacy

of training sessions in improving the screening abilities of primary care physicians. For example, in one American study involving just a 4-hour training session, the primary care physicians improved their correct referral rate from 40% before training to 85% afterwards.[19]

But improving office practice is not all that the primary care physician can do. Additionally, Diabetes 2000 has established the following guidelines for referral of diabetic patients: 1. For Type I patients, examination by an ophthalmologist annually is recommended, stating within 5 years after the diagnosis of diabetes. 2. For Type II patients, examination by an ophthalmologist annually is recommended, starting as soon as possible after the diagnosis of diabetes. 3. For diabetic patients with poor glycemic control, high blood pressure, or proteinuria, more frequent examinations are recommended. 4. For patients diagnosed with preproliferatlve retinopatny, examination by an ophthalmologist every 3 to 4 months is recommended. 5. For patients already treated with laser surgery or vitrectomy, adherence to a follow-up schedule set up by the ophthalmologist is vital. 6. For pregnant patients with Type I diabetes, examination by an ophthalmologist during the first trimester and every 3 months afterwards (until completion of pregnancy) is recommended. Ideally, women planning to conceive should be examined before conception as well.[18]

The primary care physician occupies the unique role of serving as the first line of defense in the control of diabetes and the prevention of its blinding march into diabetic retinopathy. It is to him/her that the closest contact with the patient is given; likewise, it is the primary care physician who has the most opportunities to spot the first signs of disease or to identify patients with higher risks for disease. Meanwhile, the ophthalmologist can provide more specialized care once disease is spotted or suspected. Only when the two communicate often and communicate well--only when primary and specialized care have established a strong partnership with one another--can they offer their best effort in saving the sight of the thousands at risk for diabetic retinopathy. And, as doctors approach their 150th year of doing battle with this disease, this strong partnership is not only recommended--it is essential.

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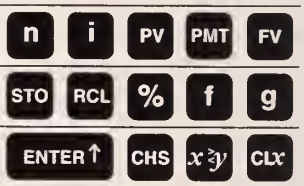
Dr. Chen is Professor of Ophthalmology and Direc tor of the Vitreoretinal Service at the University of Mississippi Medical Center, Jackson, Mississippi. Currently, he is also serving as Vice-President of the Mississippi chapter of the American Diabetes Association. ***Joel Herring*** is a fourth-year medical student and President of the Associated Student Body at the University of Mississippi Medical School. ***Alice S. Chen*** is a junior studying biology and English at Harvard University, Cambridge, MA.

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The President's Page

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No, your board of trustees hasn't authorized spending big bucks for the purchase of a fancy new computer system or a luxury automobile for Charlie and his staff.

Instead, I'm referring to our AMA delegation, a bargain at any price. Just returned from Chicago's annual meeting, these men and women elected by our House of Delegates represented us in exemplary fashion.

Veteran delegation dean Sidney Graves of Natchez rode herd on his charges like a junior high football coach exhorting his team of pubescent jocks. Prior to the AMA House of Delegates' convening, the delegation met to develop its "game plan" which included crack-of-dawn pep rallies to preview the day's agenda and to review the previous day's happenings.

In addition to attending full House of Delegate sessions, each delegate was responsible for a specific reference committee which usually began on time and ran overtime. Pertinent testimony was shared with the group so that the myriad of resolutions could be either supported or opposed. Selected to serve on Reference

(continued on page 212)

Governor Kirk Fordice Proclaims J.T. Davis, Sr., M.D. Day in Mississippi

March 23, 1995 marked the first annual Jesse Theo Davis, Sr., M.D. in Mississippi as proclaimed by Govornor Kirk Fordice. Orthaopedic surgeons and other colleagues of the late Dr. Davis observed the day by attending two lectures by Dr. Robert G. Chuinard, professor of orthopaedics at the LSU Medical Center in New Orleans and this year's J.T. Davis Visiting Professor of Hand Surgery.

To commerate the occaision, a portait of Dr. Davis was unveiled which will hang in the University of Mississippi Medical Center department of orthpaedic surgery offices. Family and friends joined for the portrait unveiling in UMC M. Beckett Howorth Library, followed by a luncheon in the Alumni Affairs Conference Room.

Dr. Davis made many contributions to patient care and to the advancement of medical care in Mississippi. He earned his MD at Vanderbilt and completed a surgical residency at Metropolitan Hospital in Cleveland, Ohio. He began practice in his hometown of Corinth in 1935 but his practice was interrupted by service in World War II. Operating on wounded soldiers in the European theatre stirred his interest in hand and upper extremity surgery-an interest which he maintained until his retirement in 1990.

He endowed the J.T. Davis Visiting Lectureship in Hand Surgery four years ago. "Dr. Davis was truly Mississippi's pioneer hand surgeon," said UMC Professor of Orthopaedic Surgery Dr. Alan Freeland. "Following his directive, we will continue his work, advancing his high values and standards. In doing so, we will be educating those people who will one day be his and our successors."



Dr.James D. Hardy, Mr.(far right) and Mrs. James T. Davis, III, shown present for the portait unveiling.

(President's Page continued from page 210)

Committee B (Legislation), which considered some thirty items, was our own J. Elmer Nix of Jackson.

The intrigue of AMA politics, participation in the Southeastern Coalition (whose members actually talk like us!), attendance at obligatory hospitality suites, and support of Alliance activities rounded out the week's schedule.

As our president, I was able to observe firsthand our delegation in action. Respected, dedicated, and polished are words that come to mind as I reflect on their performances. Just watching George McGee of Hattiesburg "work the floor" was a thing of beauty!

Decisions about health care need to be left in the hands of those who render this care rather than in the hands of those who regulate or legislate it. MSMA is fortunate to have such a knowledgeable cadre of men and women speaking out on the national level on our behalf.

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VOLUME XXXV1, NUMBER 7
JULY 1995

INFO-MEDICINE: How much is too much?

FAMILY MEDICAL CENTER
OFFICE VISIT: Mrs. Eugenia Doubtall, 55 y.o. w.f. Hypertensive
March 95:

MRS. DOUBTALL: Doctor, I've been having these awful headaches lately . . . I think I've got a brain tumor or something. Could you order me a CAT scan?
DR. SOUTH: Well, Mrs. Doubtall, your headache may very well be related to this blood pressure reading today....190/110. . . that's pretty high. Your medicine doesn't seem to be working well for you now. Let's see, your blood pressure was fine last visit and I renewed your Aldoril prescription. I wonder what's wrong?
MRS. DOUBTALL: Oh, I stopped taking that lousy stuff two months ago.
DR. SOUTH: Really? Why?
MRS. DOUBTALL: Well, when I went down to Waldo's Discount Drugs and Self-Service Gas to get my medicine....
DR. SOUTH: (interrupting) Is that the one they advertise on Channel 4 ..." the one-stop shop where you can pill-up and fill-up at the same time"?
MRS. DOUBTALL: That's right, anyway, they've got this wonderful new computer in there that tells you everything you need to know about your medicines. This printout here says that my blood-pressure medicine has been shown to be linked to the formation of brain tumors in laboratory rats and God only knows what other horrible things I can't even pronounce. At the bottom here it says "contact your physician if you have any questions about this prescription." Well, I just threw that stuff right down the toilet.
DR. SOUTH: Mrs. Doubtall, you've taken this medication for twelve years without any problem and you've had good control of your blood pressure Ma'am, does it say anywhere on that computer printout that "NOT TAKING THIS MEDICINE could cause DEATH in real-live patients???"
MRS. DOUBTALL: (unphased) This brain tumor is probably pretty big after twelve years. . maybe you should order me an MRI instead of a CAT Scan. Aren't they supposed to be better?

Fifteen minutes of educational discussion and cajoling later, we compromised on a simple change in her antihypertensive medication. She left with a prescription for a calcium channel blocker she'd seen advertised in the "Ladies' Home Journal ."

(continued on page 214)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(Editorial continued from page 213)

OFFICE VISIT: MRS. EUGENIA DOUBTALL
April 95

DR. SOUTH: Mrs. Doubtall, your pressure is still sky-high.... 180/100.... you taking that Cardizem I ordered for you?

MRS. DOUBTALL: Are you kidding? Look at this article out of the "The Tupelo Journal" last week. It says that the medicine you ordered me increases my risk of having a heart attack by 60%! Here it is in BLACK AND WHITE. I'm not taking that stuff. Waldo, down at discount drugs says he's taking Capoten for his blood pressure because it doesn't affect his sex life like the others. Could you prescribe that for me, Doctor?

DR. SOUTH: (impatiently) Well, okay. But, you'll probably be back next month with a dry hacking cough and an article clipped out of the "National Enquirer" to show me.

OFFICE VISIT: MRS. EUGENIA DOUBTALL
June 95

MRS. DOUBTALL: (wildly waving newspaper clipping) Well, Doctor, I suppose now you're trying to give me breast cancer. The newspaper says that Premarin you gave me in 1993 raises my risk for breast cancer by 46%.

DR. SOUTH: Let me see that article.... does it say anything on there about it lowering your risk for heart attacks and hip fractures by 50%? Huh? Huh?

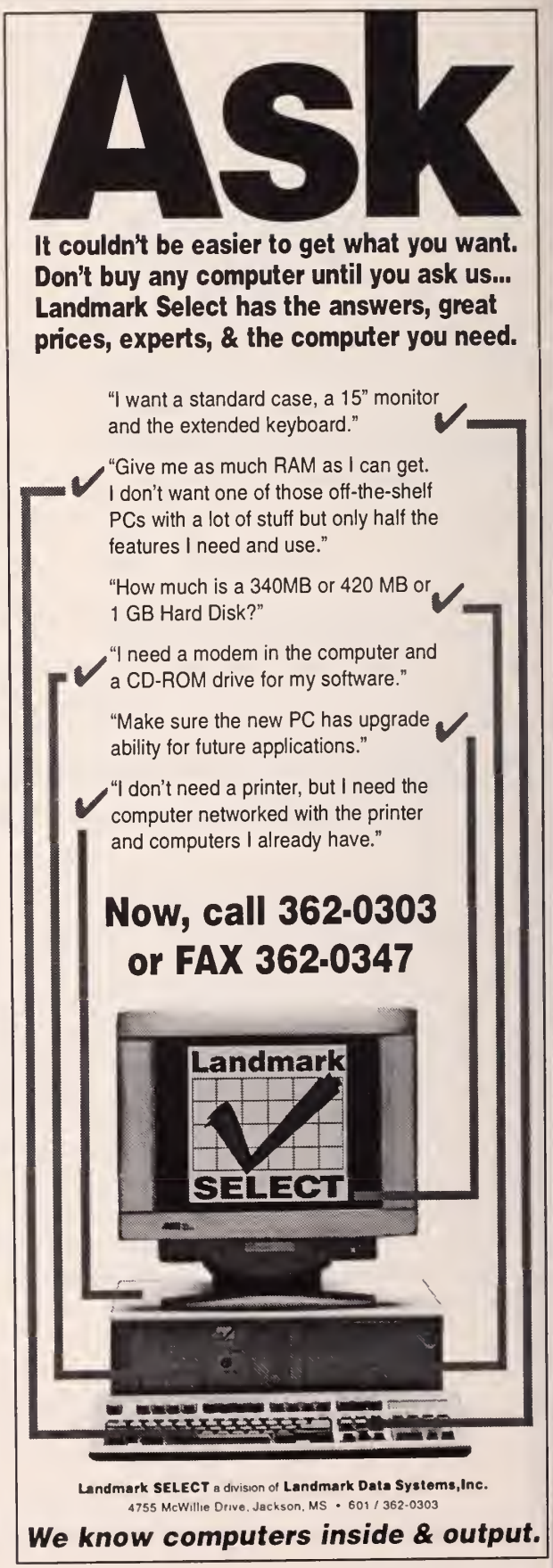
MRS. DOUBTALL: Doesn't matter, I'm not going to take it anymore. Frankly, doctor, I'm beginning to wonder if you really have my best interests at heart. What I'm here today for is a prescription for Prozac. The newspaper says it's the best thing there is for P.M.S.

DR. SOUTH: But Mrs. Doubtall, you haven't had a period in eight years

MRS. DOUBTALL: So what, I've got all the symptoms of it Headaches, weight gain, bloating, irritability, crying jags....you name it. Do you have any samples? I hear that stuff is pretty expensive.... and I don't want any genetic drugs.

I almost went and pulled out a magazine article I had clipped and filed back a few years ago which claimed that Prozac might increase the risk for suicide in some agitated depressed patients. Then I thought better of it. Hmmm....Who knows?

Dwalia South, MD
Editor



Foundation's Annual Session Highlighted with Awards and Speakers

The 24th annual session of the Foundation for Medical Care in Biloxi May 18 provided a forum for awards, recognitions, and an introduction of the cooperative cardiovascular project which will soon be underway through the Health Care Quality Improvement Program of the Foundation.

Dr. John Cook, honored as one of the outgoing board members, was named the recipient of the Arthur A. Derrick Award, in honor of the late Dr. A. A. Derrick of Durant, former chairman of the board and longtime Foundation supporter.

Receiving recognition for the Foundation's first annual quality award for excellence in quality improvement projects was Baptist Memorial Hospital at Columbus. Baptist Memorial Hospital-DeSoto of Southaven was awarded a special mention quality improvement project award.

The session, traditionally held in conjunction with the State Medical Association convention, was coordinated by Medical Director Dr. James S. McIlwain and Board Chairman Dr. George Abraham of Vicksburg. Outgoing board members Dr. Cook of Jackson, Dr. Jack Evans of Laurel and Dr. Max Taylor of Tupelo were recognized.

Physicians who were recently elected to the board to serve through 1997 were announced. They are Dr. Tim Alford of Kosciusko, Dr. W. R. Arnett of Hattiesburg, Dr. Carolyn Gerald of Brooklyn, Dr. William Henderson of Oxford, Dr. Francis Morrison of Jackson, Dr. Samuel Peeples of Jackson, Dr. Eugene Webb of Greenwood, Dr. Joe Files of Jackson, Dr. John Hassell of Laurel, and Dr. Tom Fenter of Jackson.

They join 10 physicians whose terms on the board expire next year, including Dr. Abraham, Dr. Jack Causey of Centreville, Dr. Hugh Gamble of Greenville, Dr. Barney J. Guyton of Tupelo, Dr. David Hall of Natchez, Dr. Karl Hatten of Clarksdale, Dr. Thomas E. Holden of Grenada, Dr. John Paul Lee of Forest, Dr. Glenn Peters of Louisville and Dr. Hardy Woodbridge of Jackson.

Dr. McIlwain briefly traced the work of the Foundation in its work with the Health Care Financing Administration as the state's PRO. Noting the efforts of the staff over the years in working with physicians and providers throughout the state, he pointed out that the experience of past years makes the Foundation today better able to carry out the mission of assuring quality of care through the Health Care Quality Improvement Program (HCQIP). "Rather than defining the PRO as the old or former PRO and 'today's' PRO, the Foundation represents the culmination of all the dedicated efforts over the years from physicians and staff who have made the program a reality," he stated.

Dr. Cobb's presentation introduced the cooperative

(continued on page 216)

(continued from page 215)

major focus of study throughout the state, which will be presented in detail at workshops throughout the state in August (see note at conclusion of article). Pilot projects in four states, Alabama, Connecticut, Iowa and Wisconsin, have been completed for this national project focusing on the treatment of myocardial infarction.

Dr. John Cook--
Derrick Award Recipient

The Foundation marks the third year in remembering the support and spirit of Dr. Arthur A. Derrick of Durant with an outstanding MFMC Physician Memorial Award, Dr. Derrick died March 6, 1993, in an automobile accident. He served as board chairman in 1981 and before its designation as the peer review organization for the state in 1984.

"This year's Derrick award recipient has been very active in his support of the Foundation. Many staff members cannot remember when he was not a part of the Foundation's work," Dr. McIlwain said in making the presentation. Dr. Cook has served as review physician for Medicare and for Medicaid. He has traveled throughout the state on Speakers Bureau assignments and has served as associate medical director and assistant clinical coordinator. He has also served on the board executive committee and was vice-chair of the board of directors.

A native of Meridian, he studied at the University of Mississippi, earning both his B. A. and medical degrees. He served a straight surgery internship at University, had a private practice in Brandon and Jackson, has served as chief of surgery and chief of staff at Rankin Medical Center and served as chief of surgery at Doctors. He now serves as director of emergency services at Rankin Medical Center.

"I began as the contact person for Rankin Medical in the days of the PSRO," said Dr. Cook. "When the DRG system was instituted, I was selected by the staff at Rankin to become 'the resident expert on DRGs.'" That selection, he added, led to progressive involvement with the Foundation.

His name will be listed on the Foundation's permanent plaque with the names of previous recipients of the award, Dr. Tom Fenter and Dr. Richard Miller.

Board Elects Officers
May 25

The Foundation for Medical Care Board of Directors, meeting May 31, re-elected Dr. George Abraham to serve as chairman for the next year. Dr. Samuel Peeples will serve as vice-chairman, and Dr. Francis Morrison was re-elected treasurer. Completing the executive committee are Dr. Carolyn Gerald, Dr. Glenn Peters, and Dr. Tom Fenter.

Foundation CCP Workshops Listed

Cooperative Cardiovascular Project (CCP) workshops are scheduled at six different sites in the state during August and September. They are: August 10, Greenwood Hampton Inn; August 24, Meridian Holiday Inn Northeast; August 31, Biloxi Holiday Inn Beachfront; September 7, Hattiesburg Comfort Inn; September 14, Oxford Best Western; September 21, Jackson Ramada Plaza.

The programs introducing the CCP Project, focusing on the treatment of myocardial infarction, will begin at 7 p.m. CME credits have been applied for.

For further information please call the Foundation Outreach Department at 601-354-0304.

James S. McIlwain, Jr., MD



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Below, **MSMA 1995-96 Alliance Officers**, from left: **Mary Anne Barkley,** recording secretary, Gulfport; **Melanie Moore,** AMA-ERF chairman, Singing River; **Nancy Bush**, president-elect, Laurel; **Jeanne Morrison,** president, Hattiesburg; **Peggy Crawford,** parlimentarian, Louisville. Not pictured: **Jane Ladner,** membership chairman, Jackson; **Iris Boggan,** treasurer, Decatur.



Above, **MSMA Alliance Delegates** attending the June AMA Alliance Annual Meeting were, seated from left: Past President AMA Alliance **Jeanne Hill,** Tupelo; MSMAA President **Jeanne Morrison,** Hattiesburg; MSMA president-elect, **Nancy Bush,** Laurel. Standing from left: AMA Alliance Membership Committee Member **Nancy Lindstrom,** Laurel; MSMAA Health Promotions Chairman **Cathy Gersh**, Hattiesburg; MSMAA Legislative Chairman **Kathy Fletcher,** Jackson; MSMAA Health Promotions Committee Member **Sandy Guice,** Hattiesburg.



Hattiesburg Project Wins National Health Award

Left, The South Mississippi Medical Alliance (SMMA) of Hattiesburg has won a national award from the American Medical Association, in recognition of the bone marrow drive it sponsored recently. A distinguished panel of judges, from the AMA, selected the Hattiesburg Medical Alliance from over 40 entries as the winner of the 1995 Health Awareness Promotions (HAP) Awards contest.

The bone marrow drive of the SMMA (4th largest drive in the U.S.) added 1930 people to the National Bone Marrow Registry and doubled the number of potential donors from Mississippi.

The award was presented by **AMA President Dr. McAfee** to **SMMA President Mary Cromartie** and SMMA Health Promotions Chairman **Lynn Hartwig**.



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ANDERSON, RUSSELL S., Meridian. Born Covington, KY, November 14, 1955; MD University of Alabama School of Medicine at Birmingham, AL 1982; interned one year Lloyd Noland Hospital, Fairfield, AL; radiation oncology residency, Eastern Virginia Medical School, Norfolk, VA, 1987-90; elected by East Mississippi Medical Society.

BAUER, PAUL M., Clarksdale. Born New York City, New York, February 5, 1959; MD State University of New York Health Science Center at Brooklyn College of Medicine, Brooklyn, New York 1987; general surgery internship & residency Lenox Hill Hospital & The Brookdale Hospital Medical Center, New York 1987-93; fellowship in cardiovascular & thoracic surgery Pennsylvania State University, Milton S. Hershey Medical Center, Hershey, PA; elected by Clarksdale & Six Counties Medical Society.

BHARATHAN, R.K., Crystal Springs. Born Sri Lanica, India, June 20, 1961; MD Thanjavur Medical College, Omania, India , 1989; internal medicine residency, Catholic Medical Center of Brooklyn & Queens, New York, 1991-94; elected by South Central Medical Society.

CORKERN, ROBERT S., Magnolia. Born September 4, 1960; MD University of Mississippi School of Medicine, Jackson, MS, 1988; interned one year University Medical Center, Jackson, MS; internal medicine residency University of Tennessee School of Medicine, Memphis, TN 1988-91; fellowship in emergency medicine, University Medical Center, Jackson, MS, 1991-94; elected by South Central Medical Society.

LINE, LAWRENCE L., JR., Hattiesburg. Born Ashtabula, OH, May 2, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1988; orthopedic residency, University Medical Center, Jackson, MS, 1990-94; sports medicine fellowship, Orthopedic Research of Virginia, Richmond, VA, 1994-95; elected by South Mississippi Medical Society.

LUETHJE, RONALD, Columbia. Born Washington, DC, October 5, 1952; MD Howard University School of Medicine, Washington, DC, 1980; interned same 1980-81 & internal medicine residency 1986-88; internal medicine residency, Hubbard Hospital, Nashville, TN, 1988-90; elected by South Mississippi Medical Society.

(continued on page 221)

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New Members

CA, ; radiology residency, University of South Alabama College of Medicine, Mobile, AL, 1990-94; elected by Singing River Medical Society.

RAHAT, MUZAFFAR, Stonewall. Born LaHore, Pakistan, July 27, 1962; MD Dow Medical College, Karachi, Pakistan, 1989; interned and internal medicine residency, Saint Luke's Medical Center and University Hospital of Cleveland, OH 1991-95; elected by East Mississippi Medical Society.

TSANG, BRIAN K., Jackson. Born Hong Kong, October 28, 1960; MD University of Los Angeles School of Medicine, Los Angeles, CA 1987; interned, same, one year; anesthesiology residency, Yale University School of Medicine, New Haven, CT 1988-90 and University of Southern California, 1990-91; pain management fellowship, Stanford University, Palo Alto, CA 1991-92; elected by Central Medical Society.

Deaths

BRAMLITT, E. E., New Albany. Born Memphis, TN, July 5, 1929; MD University of Tennessee School of Medicine, Memphis, TN 1952; interned one year, US Naval Hospital, Philadelphia, PA; surgery residency, University of Tennessee Medical Center (John Gaston Hospital) 1954-59; surgery residency, Memorial Center for Cancer & Allied Diseases, New York 1960-61; member of Northeast Mississippi Medical Society; died March 7, 1995, age 65.



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AIR FORCE

Deaths

CATES, ROBERT T., Jackson. Born Longview, MS, April 19, 1927; MD Tulane University School of Medicine, New Orleans, LA., 1951; interned one year, Mississippi Baptist Hospital, Jackson, MS; rotating general practice residency, Huey P. Long Charity Hospital, Pineville, LA 1952-53; member of Central Medical Society; died May 11, 1995, age 68.

FLYNT, MARTIN L., JR., Meridian. Born Mt. Olive, MS, September 3, 1911; MD Tulane University School of Medicine, New Orleans, LA, 1936; interned one year Baroness Erlanger Hospital, Chattanooga, TN; member of East Mississippi Medical Society; died May 14, 1995, age 83.

GIFFORD, WM. B., Eupora. Born March 20, 1930; MD University of Mississippi School of Medicine, Jackson, MS, 1960; pediatric residency, University Medical Center, Jackson, MS, 1960-62; member of North Central Medical Society; died June 23, 1995, age 65.

WEBB, HENRY H., Jackson. Born Gulfport, MS, April 8, 1932; MD University of Mississippi School of Medicine, Jackson, MS, 1961; interned and ob-gyn residency, University Medical Center, Jackson, MS, 1961-65; member of Central Medical Society; died May 24, 1995, age 63.

Personals

Julius Cruse and Robert Lewis, professors of pathology at the University of Mississippi Medical Center, recently published *Illustrated Dictionary of Immunology.*

Tim Alford of Kosciusko, **W.R. Arnett** of Hattiesburg. **Thomas Fenter** (executive committee) of Brandon, **Joe Files** of Jackson, **Carolyn Gerald** (executive committee) of Brooklyn, **John Hassell** of Laurel, **William Henderson** (treasurer) of Oxford, **Francis Morrison** of Ridgeland, **Samuel Peeples** (vice-chairman) of Jackson, **Jack Causey** of Centreville, **Hugh Gamble** of Greenville, **Barney J. Guyton** of Tupelo, **David Hall** of Natchez, **Karl Hatten** of Clarksdale, **Thomas E. Holden** of Grenada, **John Paul Lee** of Forest, **Glenn Peters** (executive committee) of Louisville and **Hardy Woodbridge** of Jackson have been newly elected to the Mississippi Foundation for Medicare Board of Directors.

Drs D. Stanley Hartness and **Edward E. Bryant** of Kosciusko, **Samuel M. Allen** of Quitman and **Charles P. Bass** of Columbia, have completed continuing medical requirements (150 accredited hours) to retain active membership in the American Academy of Family Physicians.

Robert S. Rhodes, professor and chairman of surgery at the University of Mississippi Medical Center, has been elected president of the Mississippi College of Surgeons.

Mary E. Hawkins of Jackson has announced the addition of a Menopause/Midlife Center to her practice of Gynecology.

Walter Mack Gorton was honored by the city of Belzoni with an appreciation day cermemony in his name held in Wister Gardens.

John C. Mutziger has been certified by the American Osteopathic Board of Family Physicians.

F. H. Savoie, III, recently presided as Chairman of the Current Prospectives on Arthroscopy of the Wrist, sponsored by the American Academy of Orthopaedic Surgeons and the American Society for Surgery of the Hand.

Wallace Weatherly has opened the new Sports Medicine & Family Orthopaedic Clinic in the Medical Arts Building in Jackson.

Paul M. Allen of Pascagoula received an Outstanding Executive MHA Student Award at the Commencement Program for the School of Health and Tropical Medicine at Tulane University.

John C. Mutziger has been certified by the American Osteopathic Board of Family Physicians.

Joseph C. Battaile has opened his psychiatry practice in Columbus.

Cynthia E. Allen and **Glenn F. Morris** are now associated with East River Medical Clinic in Flowood.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

Physicians' Recognition Award

Nineteen MSMA members were named recipients of the AMA Physicians Recognition Award in April 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

CENTRAL MEDICAL SOCIETY
Owen Beverly Evans, MD
Clarles Aaron Hollingshead, MD
Henry Edward Irby, MD
James David Polk, MD
Samuel Jobe Wilder, MD
William Douglas Perry, MD

COAST COUNTIES MEDICAL SOCIETY
Hans Werner Adams, MD

DESOTO COUNTY MEDICAL SOCIETY
Henry M. Wadsworth, MD

DELTA MEDICAL SOCIETY
Robert N. Hurt, MD

EAST MISSISSIPPI MEDICAL SOCIETY
Dewitt Grey Crawford, MD

HOMOCHITTO VALLEY MEDICAL SOCIETY
David Gene Hall, MD
Joe Dennis Herrington, MD

NORTHEAST MISSISSIPPI MEDICAL SOCIETY
Richard Meade Glasgow, MD

PRARIE MEDICAL SOCIETY
Harmon Sodney Prosser, MD

SOUTH MISSISSIPPI MEDICAL SOCIETY
Marc Scott D'Angelo, MD
Larry Hale Day, MD
Thomas Henry Blake, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

Journal MSMA Placement and Classified ads are $2.00/line, with a 4-line minimum charge of $8.00. There are approximately 50-characters per line in 11 point Times Roman type; including each letter, space and all punctuation. Ad copy must be submitted in writing.

Journal MSMA Display Classified ads 1x insertion cost $100.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camera-ready materials are preferred. Typeset ads are available for an additional charge.

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A TRIBUTE TO DR. DERRICK

We pause to remember, a life so complete,
The times with his family, so precious and sweet.
The joy that he got from music and flowers,
Of Faulkner, he spoke for hours and hours.
On scavenger hunts, he couldn't be beat,
Or the park with the seniors he wanted to treat.
He touched many lives in his own special way,
Treated patients and friends by the score everyday.
And what about the Rebels, we cannot leave them out,
How he loved to watch them, of this there is no doubt.
So, here's to Dr. Derrick, a special kind of breed,
A family man, a friend, one you call in time of need.
The respect of all who knew him from the greatest to the small,
What a memory he left us, his life has touched us all.

-BLW

Reprinted from the ***Holmes County Herald****, March 1995*

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Cervical Discogenic Syndrome: A Cause of Chronic Head and Neck Pain

Bruce S. Senter, MD

Chronic neck pain can be difficult to diagnose and treat. The differential diagnosis can include thoracic outlet syndrome, primary shoulder problems (rotator cuff tears, suprascapular nerve entrapment, etc.), Pancoast's tumor, and, more commonly, degenerative lesions of the cervical spine. Referred pain can involve the shoulder, trapezial area, arm, and periscapular area. Suboccipital headaches are also frequent. Degenerative processes are manifested in the cervical disc and facet joints. Both structures are innervated and are quite capable of producing pain without neurologic compromise, (i.e. herniated nucleus pulposus.)

Both Bogduk(l) and Zimney(2) have described the innervation of the cervical intervertebral disc. The innervation of this structure is primarily in the middle third of the annulus and consists of structures that resemble Pacinian corpuscles and free nerve endings. These neural elements are the end organs of the sinuvertebral nerve. Each spinal nerve root contributes this branch to innervate disc, facet, and other closely related structures. Pain patterns and drawings after stimulation of both the disc and the facet joints have been produced by April (3,4).

The specific injury to the intervertebral disc is thought to be that of an annular tear or multiple degenerative rents. Annular degeneration and tearing are common and usually considered a normal senescent change when asymptomatic. These defects sometimes can be seen on MRI, but usually require discography and post-discography CT. The onset of symptoms from these annular tears can be insidious or can be an acute. An injury in a motor vehicle or other accidents are common. Some studies have found that in patients with severe "whiplash" (cervical strain) approximately one-third will have permanent symptoms. It is likely that some of these patients could well have a persistent disc injury or an annular tear.

HISTORY

These patients usually present in one of two ways - they describe progressive discomfort over years or they have experienced an acute injury with persistent symptomatology. The pain pattern usually involves the neck, trapezial area, periscapular area, interscapular area, and proximal arm. Forearm and hand pain are usually minimal in the absence of any accompanying neural impingement. Headaches may also be a prominent symptom. Suboccipital headaches

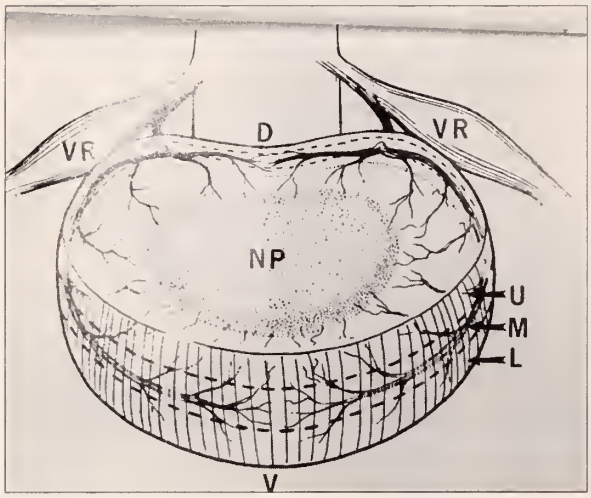


Figure 1. Diagram of cervical IVD showing distribution of nerve fibers. It is hypothosized that these were branches from the ventral primary rami (VR). D = dorsal; V = ventral; NP = nucleus pulposus; U = upper (superior) third of disc; M = middle third of disc; L = lower (inferior) third of disc. (Reference 2)

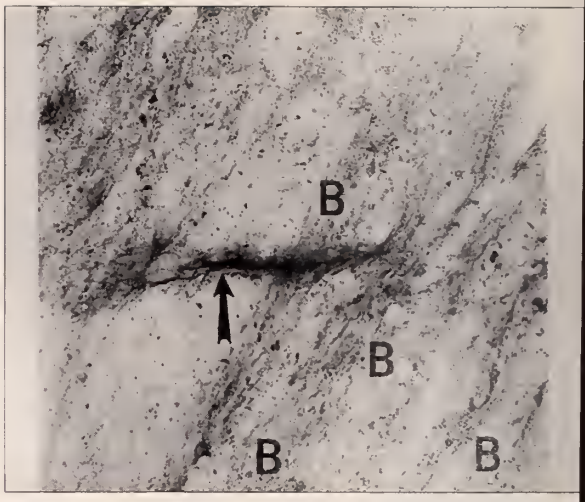


Figure 2. Micrograph of horizontal section through posterolateral portion of disc, deep with anulus fibrosus, showing nerve (arrow) passing perpendicular to fibrcartilage bundles (B). Magnification x 150. (Reference 2)



Figure 3. A Golgi tendon - like structure deep within the annulus fibrosis. (Reference 2)

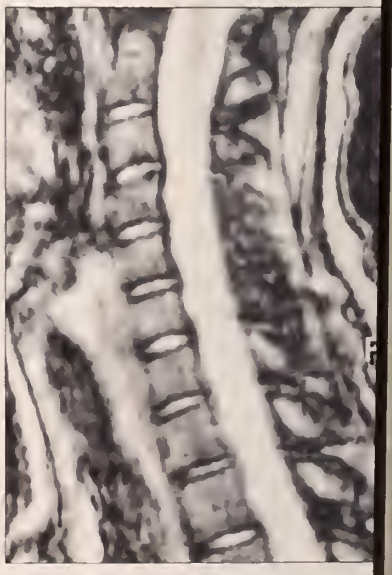


Figure 5. MRI Scan Showing minimal C3 - 4 bulge.



Figure 4. Immediate post injury lateral C-spine - normal.

following onset of the familiar neck pain are quite common and frequently occur daily. The timing of the symptoms is usually that they become prominent through the day and occur sooner the more active the patient is. Minimal symptomatology in the morning, while recumbent, is the most frequent finding. Some night pain and sleep disturbance is not uncommon but, if present, warrants ruling out a neoplastic or infectious process. Being upright with the head unsupported will exacerbate symptoms. Riding in a motor vehicle is also extremely uncomfortable for most patients. The lateral rotation required for mirror use and, probably more importantly, the low-frequency road vibration are thought to be the most irritating components of pain exacerbation upon driving.

The pain pattern is very similar from day to day and, again, the severity of the pain seems to vary with the amount and type of activity. The patients can frequently pinpoint the location of their pain. Neck collar use is usually minimally helpful.

PHYSICAL EXAM

These patients upon physical exam are usually neurologically intact. Any findings in the upper extremities are usually limited to nondermatomal sensory changes, both hypo- and hyperparesthetic in nature. Range of motion of the neck may be decreased and usually corresponds with the amount of spasm present at the time of the exam. Spurling's sign is usually absent and deep tendon reflexes are usually normal.

RADIOGRAPHIC EVALUATION

Plain films have no specific findings. Degenerative changes are usually found but may be absent. MRI may or may not show degenerative disc disease. It must be kept in mind that in patients without cervical symptomatology 35% will have spondylitic changes and that 10% of this asymptomatic population will have a herniated cervical disc on MRI. In general a herniated disc must have radicular or myelopathic findings to be clinically significant. One particular study (5) found that only 52% of their discographically painful discs had degenerative features on MRI.

The diagnosis of cervical discogenic syndrome (cervical cephalgia) is made by the history and confirmed by discography. The procedure entails placing a 25 gauge needle in the suspected discs and injecting contrast to provoke a familiar pain response. The key term is that the pain provoked should be concordant (their "usual and everyday pain"). Unfamiliar or disconcordant pain can be elicited from an asymptomatic disc. This finding is not of clinical significance. If a painful level or levels are found then testing should be continued until a asymptomatic or disconcordant level is found. Identifying the non-painful levels is as important as localizing the symptomatic disc levels.

TREATMENT

Initially, patients with this symptom complex are treated as an acute cervical strain. Conservative care consists initially of physical therapy, mild analgesics, muscle relaxers, and rest. After the acute 3-4 week period cervical traction and cervical flexibility/strengthening exercises are usually begun. Nonoperative care is usually pursued for a minimum of 6 months. The majority of patients with cervical strain/cervical cephalgia will respond.

Surgical treatment is considered by many to be controversial. Proponents(5,6,7,8,9,10,11) claim a 70-78% good or excellent result with anterior cervical fusion of discographically painful discs. There are also studies that have had significantly less success (12,13,14,15). The key in the surgical treatment appears to be strict patient selection. There are patients who emotionally are not able to withstand the rigors of the operative treatment. Also the results of successful surgery decline as the number of levels involved increases. It would be extremely unusual to fuse more than 2 levels for chronic cervical cephalgia.

ILLUSTRATIVE CASE

A 19-year-old female was involved as a restrained driver in a MVA. Neurologic exam and x-rays were normal on the day of the accident. The patient, presented approximately 1 week after the accident, complained of severe neck pain and dysesthesia of her right upper extremity. She was managed unsuccessfully with cervical traction, analgesics, heat ultrasound, massage, and exercises. Her upper extremity dysesthetic pain did resolve, but the headache and neck pain was persistent. A T99 bone scan were negative. MRI was unremarkable except for "bulging" disc at C3-4. After 6 months of this treatment the patient was offered cervical discography and potentially, anterior cervical fusion. She refused and sought treatment elsewhere.

Approximately 12 months later the patient

returned with the same complaints, incapacitating head and neck pain. She had undergone neurosurgical consultation both in and out of state, had cervical epidural blocks, and received chiropractic manipulation in her absence. She at that time agreed to cervical discography.

Discography was performed and a positive, concordant response was elicited at the C3-4 disc space. C2-3 and C4-5 were also tested and had a negative pain response. Anterior cervical fusion was performed. The patient had immediate improvement of her pain postoperatively and returned to college 3 weeks post surgery. She returned to full activity a 3 months postoperatively and at last follow-up, 6 months post operative, was asymptomatic.

SUMMARY

In patients with persistent pain of the neck, head, shoulder, and periscapular area, the diagnosis of cervical discogenic syndrome should be considered. The intervertebral disc can be a source of persistent pain and the severity of the symptoms should dictate the treatment. Surgical intervention should only be considered as a last resort in someone with significant pain who has failed prolonged conservative therapy. The success of the surgical treatment of this entity is most closely linked to adequate patient selection and rigorous patient preparation.



Figure 6. Cervical discography showing good nuclear filling with some anterior dye extravasation; C3 - 4 disc had A+ provocative, concordant pain response.



Figure 7. Lateral C - spine 5 months post - op showing adequate interbody union at C3 - 4.

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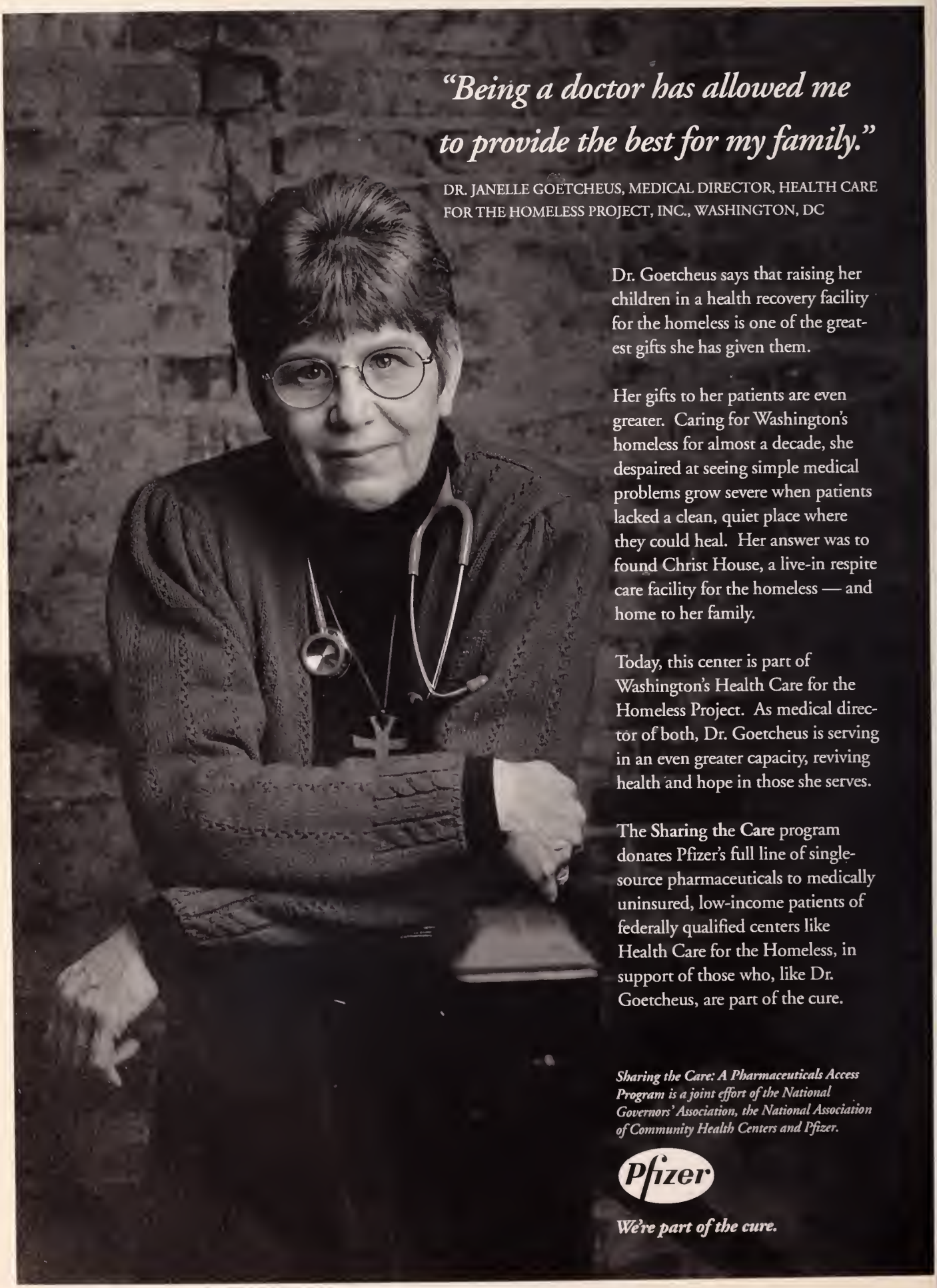
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DNA Ploidy of Thyroid Lesions

C. Ron Cannon, MD
Steven T. Hayne, MD

Predicting the course of various thyroid lesions remains a great clinical challenge. Thyroid cancer represents only 1% of all cancers and therefore collection of enough cases for statistical reference is difficult Proqnostic factors presently include the patients' age sex, histology and tumor grade.

Another area of interest is that of follicular adenoma versus a minimally invasive follicular carcinoma This diagnosis is dependent largely on the diligence and skill of the pathologist. Are there other diagnostic modalities which might differentiate between these two lesions?

Finally in benign conditions of the thyroid gland are there factors which might be predictive of the patient's subsequent clinical course?

DNA flow cytometry provides another method of investigating these questions Can the determination of normal diploid status versus abnormal aneuploid status be of use in predicting the clinical course of a patient with a thyroid tumor? DNA flow cytometry is a process in which multiple parameters may be measured as a suspension of cells courses through a beam of light usually as laser. Using this procedure detectors can measure up to 5,000-10,000 cells per second. Detectors measure light scattering at different angles by the cells and the information is subsequently stored and analyzed by an attached computer to produce a histogram for analysis. Prior to this analysis, the cells (or their isolated nuclei) are stained with a fluorescent dye that binds to the nuclear DNA. These stained nuclei then fluoresce to a degree that is proportional to the DNA content of the cell.

The flow cytometer then analyzes large numbers of these cells and a frequency histogram is generated. The actual cell number is represented in the Y-axis and the DNA fluorescence is represented on the X-axis. For normal cell populations the majority of cells are in the GO/GI phase in which some cells are resting and there is also increased synthesis of RNA. In solid tumors the percentage of cells in S phase (Synthesis of DNA) is increased Cells with normal amounts of DNA are considered diploid. Malignant tumors which contain abnormal amounts of DNA are termed aneuploid. In general, DNA ploidy has been shown to be a useful indicator of tumor aggressiveness.

The histogram generated for a diploid displays a single major peak representing the cells in the GO/GI phase. By contrast an aneuploid histogram exhibits two major peaks. One of the peaks represents the normal cell population and the other represents the abnormal cell population.

Potential uses for flow cytometry in solid lesions of the thyroid gland include the following:

1. Support for the diagnosis of malignancy in cases where morphological changes at either the light or electron or microsurgery level are equivocal;
2. Subclassification of tumors with low malignant potential provide prognostic information independent of stage, of grade and of the primary tumor.
3. Predict response to therapy.
4. Determine development of tumor relapse.

MATERIALS METHODS

The charts of 34 patients who had undergone thyroid surgery were retrospectively examined. The most common indication for surgery was that of a cold solid nodule unresponsive to medical therapy. Other indications for surgery were frank malignancy or multinodular goiter with compression of the airway. In the study group there were 5 males and 29 females.

The average age was 47 years. Ten of the patients had benign lesions, such as adenomatous, colloid, or multinodular goiters. The remaining 24 patients had a neoplasm within the thyroid gland. There were 18 patients with an adenoma, and 8 patients with carcinoma.

Within the study group the histologic diagnosis was established by light microsurgery. The blocks of tissue embedded in paraffin were obtained and submitted for DNA analysis. In each block selected, at least 75% of the tissue were neoplastic.[1] The basis of the technique is similar to that previously described by Hedley.[2] Paraffin sections of the tumor are cut into 30-50 minor sections. The sections are deparaffinized by the use of Zylene and treatment in a series of alcohol washes starting at 95% absolute and finishing with 50% alcohol. The sections are then placed in distilled water and dissected into small pieces and digested in Pepsin. The resultant free nuclei are then stained at a concentration of 1×10^6 nuclei/ml with 500 ul of 50 ul/ml propidium iodide for 15 minutes at room temperature. Following incubation with the DNA stain, 500 ul of RNase (50,000 Kunitz units/ml) is added and incubated for an additional 15 minutes.

Once the samples are stained they are analyzed using an EPICS 75Z emitting 100 mw of power at 514 nm. The data is collected obtaining 30,000 events above a threshold set on PI fluorescence. The data is then analyzed for ploidy status.

RESULTS

The results of the ploidy analysis are tabulated in Figure I. The patients were broken down into three groups. The first group was a goiter group consisting of adenomatous, colloid, and multinodular groups. There were 10 specimens derived from 9 patients. In one patient with a large multinodular goiter, a hemithyroidectomy was performed. The flow cytometric analysis revealed a diploid pattern (Figure 1). Two years later she developed a large contralateral thyroid mass with airway compression which required a complete thyroidectomy for relief of symptoms. A DNA histogram indicated an aneuploid configuration.

In the cancer group there were 8 patients. There were 3 patients with follicular cancers 3 patients with papillary cancers and 1 patient each with anaplastic cancer and Hurthle cell cancers. The patient with anaplastic cancer, and one of the patients with follicular cancer had an aneuploid analysis (Figure 2) The only death in this group of patients was the patient with anaplastic cancer. She died within several months of diagnosis with local extension into the trachea and widespread pulmonary metastasis.

The largest group comprised those patients with follicular adenoma. Of the 18 patients in this group there were 4 patients with an aneuploid analysis and 2 patients with a multiploid analysis. All of the patients in this group have done well with no evidence of development of a follicular carcinoma or other aggressive thyroid process.

COMMENT

Most of the literature regarding ploidy status in the thyroid gland has dealt with neoplastic lesions. As many malignant thyroid neoplasms are diploid, it is expected that all of the benign thyroid tumors in this study would be benign. It was interesting to note that the patient in this series with a multinodular goiter causing airway compression had an aneuploid ploidy center. In a study of 117 differentiated thyroid cancers, Camargo et al found high rates of aneuploidy in adjacent tissues which were normal histologically.[3] Perhaps this explains the aggressive clinical behavior in this particular case.

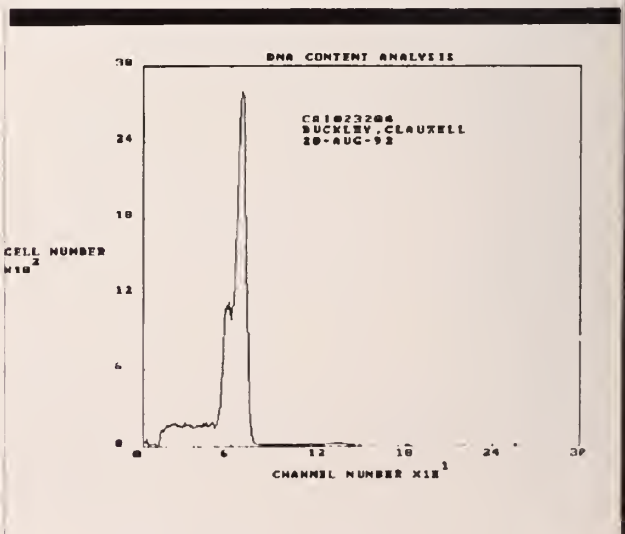


Figure 1. Histogram of a normal diploid lesion. This patient had a large multinodular

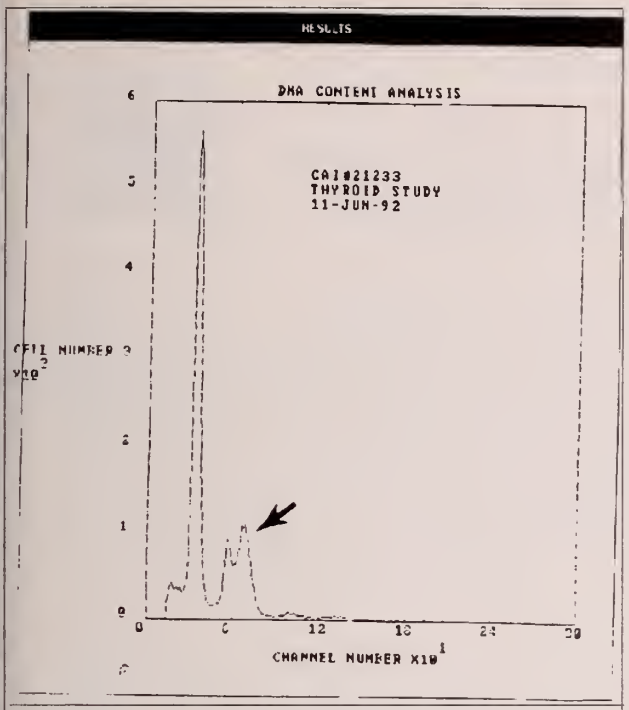


Figure 2. Aneuploid histogram demonstrating two major peaks one representing the abnormal cell population, (arrow) the other represents the normal cell content.

A diploid analysis was found in 5 of the 8 patients with thyroid carcinoma. Numerous other studies have demonstrated the finding of a diploid DNA index in thyroid cancers.[4-7] The significance, if any, of ploidy analysis in thyroid cancers is not known at this time. In a study of 36 patients less than 20 years of age with thyroid cancers, Ekman et al did not find any additional prognostic information in this group of patients.[6] Zederius et al in a ploidy study of 169 patients with follicular tumors felt that nuclear DNA content analysis could not discriminate between a benign or malignant tumor. In the study by Camargo et al, a correlation between tumor ploidy and prognostic factors, such as age and histologic factor was statistically significant.[3] Tumor ploidy alone, however, was not felt to be a significant prognostic factor. Other authors, however feel that DNA ploidy analysis provides useful information. In general the finding of a diploid tumor indicates the likelihood of long-term survival, while aneuploid analysis is associated with a more variable clinical course.[9] Tsuchiya et al found DNA measurement helpful in predicting survival of patients with thyroid cancer and an aneuploid analysis.[10]

Only one of the patients in this series died of thyroid cancer. One patient with an anaplastic cancer and aneuploid histogram died within several months of diagnosis. Survival in patients with anaplastic cancer is so abysmal that modern DNA analysis does not seem to add any additional prognostic information. In a previous study of 36 cases of anaplastic cancer all of the tumors were found to be aneuploid.[11] In a study of coexistent anaplastic and differentiated thyroid cancer only one-third of the well differentiated tumors contained aneuploid tumor cells. This suggests that in the majority of anaplastic thyroid cancers the malignant cells arise in a de novo fashion and not from a coexistent well differentiated cancer.[12]

The largest group of patients in this series comprised those with follicular adenoma. The diagnosis of a follicular adenoma versus a follicular cancer is difficult clinically and is largely dependent on the skill and tenacity of the pathologist in performing multiple sections through the capsule of the tumor. Lukas et al were the first to suggest that a follicular adenoma with an aneuploid pattern might be in the process of malignant transformation.[13] In a study by Backdahl et al the DNA cancer in 45 follicular adenomas were measured.[14] They found that DNA ploidy was valuable in distinguishing between low and high malignant potential in cases where there was tumor invasion. Another possible use of DNA flow cytometry may be in differentiating cancer versus adenoma in poor surgical risk patients. Harlow et al found DNA aneuploidy in 73% of thyroid cancers and only 36% of adenomas.[15] As DNA flow cytometric techniques can be applied to fine needle aspiration, the finding of a diploid tumor in older poor risk patients might lead to a course of medical therapy. The finding of an aneuploid analysis in this situation might prompt consideration of ablative surgery.

Determining the ploidy status of various thyroid lesions has provided further insight into this interesting group of lesions. The presence of aneuploid status alone, however, is an inconclusive indicator of cancer. In the future combining the ploidy status with other diagnostic parameters of thyroid disease may be helpful in determining malignant status.

TABLE I: RESULTS OF PLOIDY ANALYSIS

	Diploid	*Aneuploid*	*Multiploid*
Pathology:			
*Goiter N = 10**			
Adenomatous	*6*	*0*	*0*
Multinodular	*3*	*1*	*0*
Colloid	*1*	*0*	*0*
Adenoma N = 18	*12*	*4*	*2*
Cancer N = 8			
Follicular	*2*	*1*	*0*
Papillary	*3*	*0*	*0*
Anaplastic	*0*	*1*	*0*
Hurthle	*0*	*1*	*0*

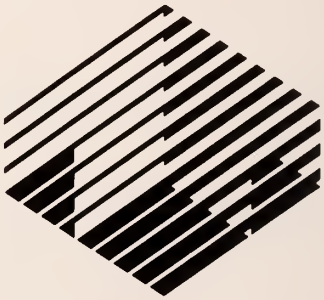
**2 specimens from one patient*

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D. Stanley Hartness, Jr., MD

The President's Page

Everything Old Is New Again

Waiting in line at our local Sunflower deli can be an enlightening activity. The elderly gentleman just behind me leaned forward and asked rhetorically, "So you knew Dr. Bailey, too?" He was obviously referring to an article which had appeared in our local newspaper on the occasion of my installation as MSMA president where the late Dr. Lamar Bailey was acknowledged as one of my role models in organized medicine (besides the fact that he delivered me).

The "too" let me know that there was more to his story. It seems that when Dr. Bailey returned to Kosciusko to join his father's practice in 1939, my new culinary friend was working at the Kosciusko Cotton Mill. Even he seemed incredulous after all that time as he reminisced that Dr. Bailey had contracted with the mill to provide medical care for its employees for 25 cents a head each pay period "whether we had a sore throat or needed an operation!"

Whether or not Dr. Bailey's "managed care" plan was unique to the time is unknown to me, but in light of today's evolving healthcare reform, it certainly has the ring of "d'eja vu all over again."

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Transcript: Remarks On Medicare Reform From the AMA House of Delegates' Annual Meeting

AMA SPEAKER DANIEL H. JOHNSON, JR.: And now, Congressman Newt Gingrich, the first Republican Speaker of the House of Representatives in 40 years, who by the way just celebrates his fifty second birthday the day before yesterday is serving his 9th term in the Congress from Georgia's 6th Congressional District. Before being elected speaker on January 4, he served as the House Republican Whip from 1989 to 1994. He is one of today's most recognizable American politicians in large because his straight talk about the issues he passionately believes in comes through so clearly.

Columnist Robert Novak says the Speaker, "...more than any other politician," has the courage to challenge the political system in Washington.

The New York Times describes Speaker Gingrich as "A thoughtful analyst who gushes with ideas." He received his Bachelor's degree from Emory University and his Masters and Doctorate in Modern European History from an institution in a wonderful part of our country-Tulane University in New Orleans. (applause). He taught history and environmental studies for eight years before being elected to the Congress in 1978. His academic and professional background serves him well, even today.

One description of the Speaker characterizes him as a man who not only reads, but regularly advises all within earshot about what they should be reading. (applause)

He proposes to transform Medicare, and we are delighted he has asked the American Medical Association to come to the table to talk with him about that.

Will you please join me now as we offer our belated but nevertheless best wishes for a Happy Birthday and perhaps even more important extend a warm American Medical Association welcome to Speaker Newt Gingrich. (applause) Let the record reflect, Mr. Speaker, it is a standing ovation for you.

SPEAKER GINGRICH: Let me say first of all I am very, very grateful for the opportunity to share with you and I appreciate the American Medical Association's flexibility-I have to be in Washington this afternoon so I couldn't come to Chicago. I appreciate very much your letting me share with you via satellite. Let me also say so all of you will see, your folks are doing their work. This is a proposal they just submitted and we are very grateful for it. It is a transforming Medicare working draft dated June 14, the 21st century-if we think of medicine and health care as an opportunity rather than a problem-then we will learn more foreign exchange in the area of health than any other sector. and I want to say to all Americans that I appreciate the positive way in which the American Medical Association is approaching the dramatic changes that we are trying to develop. I believe that you have to think about health care with a variety of areas. And essentially come down to about five. One is what do you do about Medicare? The second is what do you do-about Medicaid? The third is what do you do about veterans health care? The fourth is how do we dramatically improve the free market application here at home? What do we need to do to make health care better here in the United States? The fifth is how can we make American health care,

(continued on page 246)

(President's Page continued from page 242)

With its sleeves still rolled up after two years of intensive physician and hospital membership recruitment, Mississippi Physicians Care Network (MPCN), MSMA's entry into the managed care marketplace, recently received a shot in the arm with the signing of the largest employer group in the state, the Public Employees and Teacher group.

Under the capable leadership of Dr. Jimmy Waites of Laurel and his board, MPCN is in its second year of operation as a statewide, physician-organized and directed managed care network. With a growing membership of over 1500 physicians, the success of this venture continues to depend upon physician support and participation. Clever billboards and newspaper spreads by insurance companies and hospitals extolling their "health services" serve to remind us (and hopefully our patients) that no one other than the physician can provide the essential component--the practice of medicine--for the real truth in advertising.

MPCN can be our effective healthcare delivery system as the winds of change blow over our profession. Although we can't necessarily adjust the wind, by becoming active supporters and direct participants, we can adjust our sails.

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QUALITY TIME

It is the fourth Tuesday again, another executive committee, and the quality improvement report drones on. It ends, finally, with an item that the medicine section has dictated 100% of its histories and physicals within 24 hours of admission. "Fantastic," exclaims a proud administrator after the narrator has paused for effect.

Such is the level of quality indicators these days. Whether the content of the histories bore any relation to the clinical situation or whether the care rendered was appropriate was never at issue. But by this measure the surgical section was easily outclassed. That bunch of laggards limped home at a meager 78%.

So if this measure of compulsiveness is a poor measure of quality, what measure would serve the purpose? What level of quality is given to an office visit during which some reassuring words relieve a patient of a sense of impending doom? Or another series of visits guiding a patient with a hopeless case to a merciful death? In fact no true measure of a doctor's quality of care exists beyond the subjective judgments of the peers working with him. The Health Plan Employer Data and Information Set, developed by the National Committee for Quality Assurance and representatives of employers and health plans, is the most prominent of recent lay efforts to evaluate quality. Yet its nine measures of quality focus on provision of preventive services, such as mammography, PAP smears and cholesterol screening. Only two indicators, low birth weight and hospitalization rates for asthmatics, even loosely measure outcome, and neither is adjusted for risk.

The urge, however, by lay groups, to evaluate medical care quality will not be quenched, particularly with an increasing array of health plans to pick from. In late June, purchasers of health care for eighty million Americans, the group including HCFA, 3M, American Express, Pepsico and others, announced a joint effort to measure the quality of care provided by health plans.

Should we boycott these crude efforts to rank us, practitioners in a field that is as much art as science? The answer is, no, we shouldn't. Though the report cards laymen seek can never replace credentialing, accreditation, and peer review, they will serve important functions. Without them price will provide the only layman's distinction between health plans, and the competitive pruning that follows will be catastrophic for quality of care. Doctors will need to take a role--the lead, actually--in improving these cards so that some form of crude but true measure can be taken, taking risk into account so that health plans cannot improve their score by selecting only healthy persons, or deselecting doctors working with the very ill. The job would be difficult and ongoing. However, to do otherwise is to oppose the issue of more standard information to patients, information that might just educate us at the same time.

Leslie E. England, MD
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(*continued from page 243)*
American pharmaceuticals, American medical technology-how can we take all of these opportunities and turn them into the terrific potential for foreign exchange earnings that we should have in the 21st century. I believe in the 21st century - if we think of medicine and health care as an opportunity rather than a problem - then we will learn more foreign exchange in the area of health than any other sector. So I am very optimistic about our ability to lead the world in providing the best health and the best health care and therefore have people from all over the planet as they get wealthier saying, "I want the American version of good health."

One thing we know is that if your choice is to be taken care of by any socialized or nationalized health care system in the world or to be taken care of in America, that people all over the planet when they get a chance, prefer the American model. That's why recently when I met with King Hussein of Jordan the day after he was in Washington, he was in Rochester, Minnesota at the Mayo Clinic for his annual physical and I believe his entourage age took up about half of the hotel, thereby providing a substantial increase in the income of the Rochester, Minnesota area (laughter) - as well as increase the Minnesota state government. My point is that health is not just a problem, health is also an opportunity and working together with the American Medical Association, I think we can make a tremendous difference and that's why-unlike Ira Magaziner-we have actively reached out to ask the AMA to be at the table just as we have asked AARP and the American Hospital Association and the health maintenance organizations and everybody who has a good idea because our attitude is, let's get all Americans together to talk about this and then we'll find a solution.

Remember, despite what you occasionally hear from some of our left wing critics, we're talking about a solution that spends more money on Medicare, not less. We don't cut anything in Medicare or Medicaid. In both cases, they go up. In the case of Medicare, we go up from $4,800 a year to $6,400 a year per senior citizen during the seven-year process. Now that's an increase, about a 33 % increase in how much we'll spend per senior citizen. And the challenge to all of us is to find a less expensive, better way of delivering health care services. And when I talk to doctors and they say, do you mean without Health Care Financing Administration, without lots of red tape and bureaucracy, being able to focus on the patient rather than the bureaucrat? I find a very positive, excited attitude about the kind of options, particularly, because we are not going to go simply to one brand new replacement. We don't believe that we are that smart. We don't think that we can come up with the one answer that will work. So what we've suggested is, let's come up with a number of different opportunities. Let's have a medical savings account option, let's have a coordinated care option, let's have a direct fee for service option. Maybe we ought to have an option where people can literally opt out of the system, get a voucher so they can buy any insurance they want if they are wealthy, they can self insure, and then if they want to go to the best specialist in the world, at the most expensive place, we don't mind if that is their money they have saved all of their lives and they want to do it. Give them freedom, not bureaucratic control. (applause)

I don't want to cut you off, so I apologize. No good politician wants to stop people from applauding. I hope you'll forgive me due to the technicalities, I don't quite react fast enough but I want you to persist. (applause)

Also, let me say that we want the idea- we might want to stay in our current health care system. If you're in a really good group insurance and you like it, maybe the answer might be for us to give you a voucher for Medicare and then you stay in the insurance you've already got, with the people you already know, using the procedures you already approve of. We're looking for five or six or seven options so every citizen can chose so every citizen can be a customer rather than being trapped by the government into being a case in the bureaucracy. Let me also say we've asked the AMA to give all of you a two-page article out of the *Newsweek* (*Business Week*) outlining the nine strategies that we have to undertake. I don't want to deal with this in detail because I want to take most of the time with questions, but because of the quality of the group, I want to give you a very quick outline.

First of all, I believe when you are designing anything, in your business or your practice, your career, the structure of medical care, the nature of the Republican party, that it helps you if you do your planning and your management in four layers. You can then decide what layer you are working on. It's a very simple model-it's just four words. Vision, strategies, projects, and tactics. I think you first have to decide what is our vision for future health care? The reason the Clinton plan failed is that at the vision level, their vision was a government dominated bureaucratic controlled system. People did not reject it because of the details. People rejected them because their core vision was not a system people felt very good about. They've seen the Post Office, they've seen the IRS, they've seen the Pentagon. They weren't sure that having this government run their health care was the best idea.

(applause)

Second, once you have a vision, it has to be laid out. You've got to figure out the strategies to achieve that vision. The third level then, once you have your vision and your strategies thought out, you have to build projects. I think of a project as a building block. You have a whole series of design strategies and a project is a definable, delegatable achievement. You might think of it as something where you can turn it over to someone else and when they get done with it, you don't focus on the process you focus on the achievement. This in an entrepreneurial not a bureaucratic model. And then, finally, you look at tactics, what do you do every day? In our case, we believe we have to engage everybody in the country so one of my major tactics, frankly , is to do as many speeches, as many talk shows, as many interviews, to get people engaged intellectually in understanding where we are going and what we are talking about. If you take this model of vision, strategies, projects and tactics, that's how you think about where you are going. That's just you. Now you've got everybody else in a free society.

We have a second model-four words, it's very simple. It's a process and the first word is listen, learn, help, and lead. We believe you should literally start by listening to people, so if we want to do something on health care, we try to get everybody who knows something about it and listen before we tell them, but it's not just transactionally, being at a cocktail party where your eyes glaze over, and you hope that you look like you're listening. We're talking, really listening so you actually learn from people. Now if you listen to people, and you learn from them, you can probably help them. In a rational society, if somebody knows you will listen to them, learn from them and help them, they want you to lead. When they want you to lead, they say okay, I'm convinced, why don't you lead. You then say, here's my vision. Here are my strategies. Here are my projects. Here are my tactics. Then, you go right back to listening. Because now you have to find out what is their reaction.

Think of what we're doing in the sense that senior citizens, with the AMA, with the hospitals, with everybody involved, we're saying, we have a general vision of a free market health care system in the information age where every senior citizen becomes a customer. Now, you help us figure out the details. We believe we have to replace the centralized command bureaucracy of the Health Care Financing Administration. That's the advice we are giving to the Russians. Let's centralize command bureaucracy. Let's try it here in Washington before we preach it in Moscow. (applause)

Now I believe if you take this model, we have three national goals for the next decade, we have nine national and most is outlined in the *Business Week* story. I'm going to say this briefly. Our first goal is to communicate the vision of a successful twenty-first century. Think of an America that is prosperous, safe, healthy, where people feel good about being Americans and we can lead the world. Because we want people to have a positive image of what we are working to achieve. We need the energy and the drive to get there. Second, we believe that we have to have as a goal creating a genuine dialogue.

I'm talking to you today to start the process of dialogue which I think all of you know we are very serious about here in Washington. It's got to be a dialogue, not a debate. It's got to be a chance to sort out ideas, and to explore things. And recognizing, given the scale of change we are trying to pull off, we don't have all of the answer. We need a lot of people and a lot of ideas and then we need a lot of discussion to make it work for real. And then the third, we have to have a goal of creating a sense in every American of being a partner in where we are going in this country. We can't solve these problems in Washington, D. C. We have to have every American committed. The Constitution begins, "We the people of the United States"-now, it doesn't say "we the taxpayers, we the bureaucrats," it says, "We the people."

And what we're trying to reestablish is the idea that in your family, your neighborhood, your community, in your business, there are all sorts of ways to be a partner in creating a better country: That also means, if we are going to reach out a helping hand to the poor, then as partners, they have to reach out a helping hand too. If we're going to reach out a helping hand to a drug addict or to an alcoholic, they have to reach out a helping hand too. It's impossible for us to do for people what they're unprepared to help do for themselves. That's a very different attitude than the welfare state we have had for the last thirty years.

In that framework, a positive vision, real dialogue, real partnership, I think there are nine strategies in the Newsweek (BusinessWeek) article. Let me just say, first, for a new American civilization, reestablish the work ethic. Insist on English as the common language. Establish the notion that America is multi-ethnic, but one civilization and has been for almost four hundred years. Second, compete in the world market. Do the things necessary so our children and our grandchildren have the best jobs and the highest value added with the greatest productivity

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producing the best take-home pay so they have the perfect choice of quality of life. Third, really dramatically enter the information age. All of you know, we are watching revolutionary changes, we are entering the age of molecular medicine. We have dramatic capacity of virtual reality, with microminiaturization, just thousands of breakthroughs that we frankly don't know how to integrate into our society right now. So we have to accelerate getting into the information age to compete in the world market to give our people the best choices in the future.

Fourth, we want to replace the welfare state with an opportunity society. The concept that some bureaucrat can redistribute wealth in a way that turns you into a victim so that you live in a controlled bureaucracy, is a total disaster and we see it every night on television. If we could simply replace the culture of poverty, drug addiction, and violence with a culture of prosperity, health and opportunity, you would lower America's health indicators overnight. If Friday night emergency wards weren't filled in every major city, we'd be a better country. If Indian reservations didn't have the level of alcoholism and addiction and teenage suicide they have, this would be a healthier country. A large part of our health crisis is a crisis in our culture, it is not a crisis in health care, and it's caused by the welfare state's bad ideas and bad values and we have to replace them. (applause)

Fifth, we have to be prepared to decentralize power away from Washington, D. C. This is too big a country. It is too complex for a bureaucratic Washington to understand Bangor, Maine and San Diego, California, Miami, Florida, and Anchorage, Alaska. It's just too big a country. So, we've got to get power out of Washington back home so local governments are making local decisions about local opportunities and we've got to get it out of government entirely and back to you. So that you have more money in your pocket and more power and you and your family will be making more decicions about your lives.

Sixth, there is alot of federal government that will still be here-we're going to be a pretty big system under any circumstances. Every aspect of the Federal government will be benchmarked for excellence. We have to try to be the best in the world. We're going to have a National Institute of Health that's going to be the best in the world. If we we're going to have a Center for Disease Control, let's make it the very best. Anything worth doing by your government is worth being excellent. And if it isn't worth doing excellent, let's quit doing it. That's the standard you ought to set in Washington, D. C. (applause)

Seventh, we need to make sure Medicare and Social Security are reliable trust funds. This is an enormous challenge. But when you learn that a child born this year (transmission difficulty) $85,000 that they will pay in interest in their lifetime, you know that we have to have very major changes. So, with your help, we will work very hard to get the balanced budget and with the balanced budget, we're going to save Medicare which the Clinton Administration's trustees report will go broke by 2002. We will take the steps this year to preserve and protect Medicare. And improving it with new approaches that are more free market, more competitive, use better technolo-ies with better science than the Health Care Financing Administration red tape riddled bureaucratic structure. So, we're going to take that very seriously.

Eight, we have an obligation to create a safe America by suppressing violent crime to no worse than the European levels and by breaking the backs of the drug trade. It's doable. It takes willpower. But's it's very hard to do in terms of sheer determination. The fact is very simple. We are the only country large enough, complex enough, multiracial enough, to reach out to the entire human race. When we fail to reach out, we get Bosnia, Chechnya, Somalia and Rowanda. If we are going to lead the planet to its freedom and prosperity safety, or if we withdraw, it's going to become a dark and bloody planet for our children and our grandchildren. This is a huge set of goals. Three big goals, nine major strategies, and I ask you citizens to look at it and take it seriously. I can tell you the American Medical Association is playing a major role in helping us work with several of these goals already and we'll be back talking to you more about how to do all of them. In that framework, it's your support, your ideas, your approaches on how to deliver healthcare so that we can go from $4,800 a year this year for senior citizens to $6,400, a 33 % increase and deliver the care. What changes, what improvements, how can we make it work? We really want to work with you. And, in that tradition, I like to now, if you have a few minutes, is to stop and take questions or listen to comments. (applause)

DR. JOHNSON: I've been a physician for many years and the fact that you are willing to have us at the table to give our input, our thoughtful input, is something that we appreciate very much. And we have asked our physician members of the House of Delegates to offer questions both in advance and also today. I'd like to begin now to read one of these to you and invite you to respond. Mr. Speaker, it seems that our President now wants

to consider the necessary transformation of Medicare that I consider in his recent budget proposal is the same old thing, cuts on doctors and hospitals so that a shared sacrifice by the well heeled and elderly, how will Republicans respond to the President without shutting the door to bipartisan solutions.

MR. GINGRICH: Well, I'd say, first of all, I'm not sure we have to cut anyone. I think what you have to have is a competitive environment where people make real choices and where they take money out of paperwork and out of bureaucracy and frankly out of legal fees which you all know we passed a substantial part of the litigation reform in the House which the AMA strongly supported. (applause)

Our goal is to get efficiency in the system with better service and better ideas and craft renovation without just hurting doctors or hospitals or patients but then I am an optimist. But I think that is the history of free enterprise is to have new ideas and new approaches and new services often at lower cost. We're going to try to engage the President-let me be very clear about this-Senator Dole and I spent a lot of time talking about this and we believe that it is very important that we try to get the President engaged. I thought it was a step in the right direction that he was willing to concede "yes, we have to balance the budget that was a change from where they had been. Yes, we could do it while cutting taxes-that was a change from where they had been. Yes, there have to be some changes in Medicare and I agree, you look at his underlying documentation, it's the same old liberal democratic-anti-hospital, antigovernment, anti-provider attitude. At least it ceded the principle that we do have to do something to save the trust funds from going broke-that was a step in the right direction.

We did have control over domestic spending in a way that's brand new. There were no more cuts in defense spending which I thought was good considering what happened to Captain Scott O'Grady recently. The fact that we have to have a strong enough defense to give our young men and women the strongest possible chance of surviving m battle so I thought it was sort of a first step-the principles were very encouraging-what I found discouraging was when the Congressional Budget Office scored the President's documents, they came in with absurdly bad numbers bad I'd like to think that this was just bad staff work on the part of Leon Panetta and Doctor R... of the Office of Management and Budget and was not a deliberate deception on the part of the President. When you look at the underlying numbers, it's about $200 billion dollars a year off which is not a balanced budget, if you do your checkbook that way, you can go to jail.

But if we can find a way to work with the President on real reform, I think that's better frankly than a series of ego fights and so our war is over but it's only over when I said the week after I was elected to be Speaker back in November I said that we would cooperate but not compromise. And that's very important. We're not going to compromise our principles. We're not going to compromise when it really matters. We'll insist on a balanced budget-we're going to insist on more freedom inside the health care system. We want a system where doctors have the chance to be competitive and that senior citizens come out from under a monopolistic control by the Federal government and out from under the red tape and frankly from things that make no sense. If they are successful and have worked all their lives, and they want to spend a little extra and go to the ophthalmologist they like, why should the rest of us care? That's what freedom should be all about. (applause)

But I was encouraged and I'd like to take it as the first step and not slam the door.

DR. JOHNSON: Mr. Speaker, you touched on an issue of some considerable interest to us for many, many years now and that's tort reform and I'd like to read to you a question. What are the chances of significant tort reform coming out of the House/Senate Conference particularly a cap on non economic awards.

MR. GINGRICH: Well, I can lobby for you here. It would help a lot if all of you go home to meet with your Senators. We proved in the House that we can pass a very strong bill. I think we shocked the trial lawyers on the three bills we passed. One had a 300 vote majority, which I thought was amazing considering how long the trial lawyers have been fighting. We only had one third of the Senate stand for reelection last year. They didn't quite get the same intense message the House did. And so, despite the best efforts of the Senate leadership, we were not able to get a stronger bill. I believe we're better off to slow this down for a few months and give every one of you a chance to go meet with your Senator to see if we can't get a little more support for a strong bill rather than accept a weak bill. Our strategy is going to be to do everything we can to get the strongest bill out of the House/Senate Conference.

DR. JOHNSON: Mr. Speaker, this next question says "We applaud your leadership and vision for America but are concerned in the drive toward a balanced budget that our Medicare patients could be hurt by their being

(continued on page 250)

(*continued from page 249*)
forced into managed care arrangements. What safeguards do you envision be put in place to assure that our patients are protected and that physicians can continue to give needed care?

MR. GINGRICH: Well as I think I've indicated here today our goal is to offer five or six or seven choices to every senior citizen-to say to them, if you want to stay in the current system, exactly as it currently is, we are not going to take you out of it. Over time, I think you'll see some deductibles go up, some copayments go up across the whole country. But it's not going to be dramatic, and we're going to protect your rights. I don't want to go up to someone who is 75 or 85 or 95 years old and say to them, "we're going to coerce them." That was the Clinton Administration plan to coerce them. We're not going to do that.

What we am going to do is say, "Here are five or six or seven choices. If you like the medical savings account model, here it is. " The most interesting model I've seen frankly is International Paper which has a system where they go into a town and they find out from every doctor and every hospital what they charge for each procedure or each service, they list all of them, they pay 100% of the median cost for that community and give that out as a voucher and then they say to people you go find any doctor you want, you go use any hospital you want, we'll pay the median, the 50 percentile level. Anything above that, you pay out of your own pocket. The result has been people love the choices. They're coming out of the HMO because International Paper also has an HMO plan. They're leaving the HMO to go to what I call "self-managed care." We want five or six options, one of which could be managed care. There would be a beck of a lot of alternatives and that's why we asked the AMA to help us design a set of alternatives so people could choose and then I think you're going to see a lot of different options-you're not going to see anyone rushing off and be corralled into one solution only.

DR. JOHNSON: The International Paper model is best expressed by what we call a Benefits Payment Schedule and I commend that to your attention. I would like to direct a question to you from your own Georgia Delegation the physicians who represent the physicians of Georgia and their patients here in the House of Delegates, and the question is as follows: "The physicians are concerned that the Medicare cuts and the physicians use the term 'medicare cuts,' Mr. Speaker, that the medicare cuts required to balance the budget, may adversely effect access to the health care system. Could you please comment?

MR. GINGRICH: We feel that what we are doing is being driven by the trust funds-you only have a couple of choices with the trusts-you can increase the FICA tax on everyone and have everybody increase their payroll tax don't think frankly younger families with children ought to have their taxes run up, so we're very resistant. I don't think small businesses, including by the way, doctor's offices and doctor's practices, need to have their payroll taxes going up. If you're not going to do that, then where is the money going to come from, and how are you going to solve this? So even if we weren't trying to balance the budget, we would have an obligation in the Part A Medicare area to do something pretty dramatic. Second, the original preface of Part B was that 50% of the money would come from the person being covered and 50% would come from taxpayers. That's now down to about 69-31.

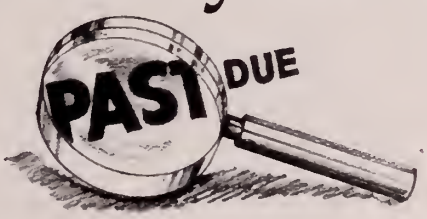
We think that that's a big mistake. It's asking too much of the taxpayer who is still working and we're not frankly involving the patient in enough of their own involvement in paying a fair share of what is after all an option for them where we're helping them. My challenge back to you is simple. I'm told that most doctors at HMO's have something like 25-28 % overhead in bureaucracy. We also know that the Health Care Financing Administration and all of its intermediary insurance companies have a lot of bureaucracy. If you can help us find better ways to structure the system, then I believe that for $6,400 per senior citizen at the end of this cycle, we will in fact be able to provide pretty darn good health care. I don't think $6,400 per person for health care is a tiny amount. But obviously, we have to work together to make it happen, and we need your help and your advice in how to do it in such a way that increases the range of choices that gets the paperwork and the bureaucracy out of the way but keeps the health care in.

DR. JOHNSON: Mr. Speaker, can you give us a comment on what your position is on block grants to the states? The Academy of Pediatrics is particularly concerned about access to care.

MR. GINGRICH: Well, our platform, with some safeguards written in by the Federal Government, is to block grant Medicaid back to the states because we believe we will get less expensive administration and have a more local oriented and more immediate administrative oversight. We believe that the local experiments in Arizona and Wisconsin, to take two examples, that it is possible to deliver Medicaid much less expensively than the current Federal model. And again, I talk to doctors all of the time who are astonished at the scale of waste and

total abuse of the system that they see in Medicaid where their partners in Federal Government to do a number of things that make no sense at all. That will require frankly that the lot of effort be directed at the state legislatures. And we ought to suggest to the people that you better be more involved in your local elected officials because they will have more relative power and more relative control. So I think most people would agree that if your choice is to try to run the whole country from Washington, or decentralize back to the 50 states and have people in Georgia and the Georgia legislature deal with Georgia problems then we will have a less expensive and more effective solution in Georgia. I'm going to have to run, but let me say, I can't leave without thanking all of you. Your American Medical Association is a very important contributor to better health care and to better health in America. What you're doing in working with us I think is vital to bringing a sophisticated and intelligent solution to the future and I can assure you that my door and frankly the door to the House Republican Party and the Committee Chairman and Subcommittee Chairman are always open to sit down with AMA experts and to listen to the AMA ideas and the approaches you're developing so I want to encourage everyone who is here today in Chicago. If you'll come forward with positive, innovative new approaches, we're going to listen to you seriously. It is the only way we can create a better twenty-first century America for our children is for us to work together as a team. Thank you all very, very much. (applause).

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Foundation For Medical Care To Participate In National Cooperative Cardiovascular Project

The Foundation for Medical Care will participate in the Cooperative Cardiovascular Project (CCP), a national quality improvement project based on pilot studies conducted in four states. The neighboring state of Alabama was one of the pilot locations that worked with the Health Care Financing Administration in developing the rationale, methods and procedures for this important project. Results from the four pilot states indicate that there are significant opportunities to improve the quality of services provided to Medicare patients with acute myocardial infarctions (AMIs).

Quality indicators for acute myocardial infarction were based on the Clinical Guideline for AMI by The American College of Cardiology and endorsed by other professional groups, including the American Academy of Family Practice and College of Physicians. The indicators cover reperfusion (thrombolytics and primary angioplasty), aspirin therapy, use of beta blockers, smoking cessation, and the management of poor left ventricular ejection fraction through the use of ACE inhibitors and the avoidance of calcium channel blockers.

As the project developed into a national effort and with the recommendation of the American College of Cardiology, two indicators in the pilot project were dropped. These indicators were intravenous nitroglycerin for persistent chest pain and low dose heparin for prevention of deep vein thrombosis. While these two treatment modalities have selective usage, it was determined that the remaining indicators were of a higher priority.

Review results in the pilot states showed crude rates of utilization to be 18% for thrombolytics, 35% for beta blockers and 66% for aspirin. The timing for thrombolytics was less than the minimal achievable in a high percentage of cases. These crude rates are not fully reflective of the appropriate utilization of these therapies due to significant numbers of patients having one or more relative contraindications for each therapeutic intervention.

CCP project methodology involves abstraction of all AMI records over an eight month period for Medicare patients. These records are sent to a national data abstraction center (CDAC) where critical data items will be abstracted to determine compliance with several clinical indicators. Data tapes for all cases abstracted from Mississippi will be forwarded from the CDAC to the Foundation where staff will analyze the data and also prepare and present a report to each participating facility. No report cards or other hospital-specific reports will be made public. Each hospital will review its data with comparative data from a national sample, a state sample and in some instances, aggregate data from its peer group of Mississippi hospitals.

Each facility will present a plan for improving practices and/or processes to achieve a pattern of care for AMIs that more closely complies with the recommended "best practices" as proposed under the guidelines. After

implementing improvement plans, each facility will be encouraged to measure its changing practice patterns. The Foundation will monitor the overall practice pattern change in the state for AMI as a basis for project evaluation.

Foundation staff are looking forward to interacting with participating hospitals and their staffs on this exciting and important project.

Foundation For Medical Care To Conduct Regional CCP Workshops

The Foundation for Medical Care will conduct six regional workshops focusing on CCP. Dates and locations include: August 10, Greenwood, Hampton Inn; August 24, Meridian, Holiday Inn Northeast; August 31, Biloxi, Holiday Inn Coliseum; September 7, Hattiesburg, Comfort Inn; September 14, Oxford, Best Western; and September 21, Jackson, Ramada Plaza.

Workshops are limited to 50 people and will begin with registration at 6:30 p.m. and conclude around 8:30 p.m. Continuing Medical Education (CMEs) credits have been applied for. To register or for more information, contact the Foundation's outreach department at 601-354-0304.

James S. McIlwain, Jr., MD
Foundation Medical Director

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Call For Papers

Uncertain Times: Preventing Illness, Promoting Wellness

1996 International Conference on Physician Health

February 8-10
Chandler, Arizona

Authors are invited to submit abstracts for consideration as part of the 1996 International Conference on Physician Health, which is sponsored by the American Medical Association, the Canadian Medical Association, the Federation of State Medical Boards, and the Federation of Licensing Authorities of Canada.

Presentations dealing with any aspect of physician health, including issues of well-being, impairment, disability, treatment, and education are welcome. Of particular interest are:

- Coping with changing economic or practice circumstances
- Stress and physician health
- Epidemiologic data
- The effects of violence directed at physicians
- Violence occurring within physicians' families
- Patient exploitation
- Mental illness, including substance abuse
- Physical illness and disability
- Special populations
- Comparative data across states or countries
- Physician well-being and family functioning
- Updates on clinical areas (depression, pharmacotherapy, etc.)

Three types of presentations are welcome:

- Poster presentations: written presentations of data-based research
- Paper sessions: Oral presentations of scientific, data-based findings on issues of physician health. Paper presentations will be grouped into related panels, with individual papers presented in 20 minute time slots
- Workshops: Training or instructional presentations designed to improve the skills and knowledge of persons working in the physician health field

Abstracts for all presentations must be submitted on the abstract submission form which is available from: American Medical Association, Physician Health Program, Attn. E. Tejcek, 515 North State Street, Chicago, IL 60610.

All presenters must register for the conference and will pay the AMA member rate. Presenters will be responsible for their own expenses.

Deadline for submission is October 2, 1995

Questions or requests for abstract submission forms may be sent to the address above or directed to 312 464-5066 or faxed to 312 464-5841.

American Medical Association

Physicians dedicated to the health of America

New Members

BARNES, CHARLTON H., Pascagoula. Born Decatur, IL, January 4, 1942; MD University of Illinois College of Medicine, Chicago, IL 1967; surgery residency, same, 1968-69; orthopaedic surgery residnecy, Wayne State University Medical School, Detroit, MI, 1969-72; elected by Singing River Medical Society.

BONE, KEVIN H.,Tupelo. Born Columbus, MS, September 24, 1962; MD University of Mississippi School of Medicine, Jackson, MS 1989; interned one year, Vanderbilt University Hospital, Nashville, TN; urology residency, University of Tennessee Health Science Center, Memphis, TN, 1990-95; elected by Northeast MS Medical Society.

BRILL, THOMAS M., Jackson. Born Jackson, MS, July 1, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1993; family medicine residency, same, 1993-95; elected by Central Medical Society.

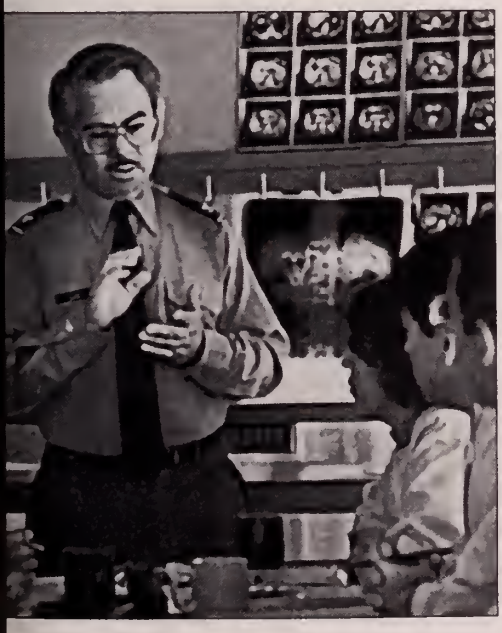
BURKE, RONALD G., Jackson. Born Austin, TX, September 10, 1960; MD University of Texas Health Science Center, Houston, TX, 1984; orthopaedic surgery residency, Fort Worth Affiliated Hospitals, Ft. Worth, TX, 1989-94; orthopaedic fellowship, University of Utah, Salt Lake City, UT, 1994-95; elected by Central Medical Society.

CAUSEY, ALAN L., Jackson. Born Santa Monica, CA, July 25, 1958; MD University of Mississippi School of Medicine, Jackson, MS, 1989; pediatric residency, same, 1989-92; elected by Central Medical Society.

CEGIELSKI, CAROLYN H., Laurel. Born Jersey City, NJ, September 19, 1963; DO University of Medicine & Dentistry of New Jersey, New Jersey School of Ospeopathic Medicine, Camden, NJ, 1989; interned one year same; internal medicine residency, Kennedy Memorial Hospital, Stratford, NJ, 1990-93; gastroenterology fellowship, same, 1993-95; elected by South MS Medical Society.

COOK, CURTISS B., Jackson. Born Detroit, MI, Wayne State University School of Medicine, Detroit, MI, 1985; interned, internal medicine residency &
(continued on page 256)

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endocrinology fellowship, The University of Michigan Hosptals, Detroit, MI, 1985-91; elected by Central Medical Society.

CRANE, GWENDOLYN A., Gulfport. Born New Orleans, LA., June 14, 1958; MD Tulane University School of Medicine, New Orleans, LA, 1987; interned one year, University of Alabama Medical Center, Birmingham, AL; dermatology residency, Northwestern University School of Medicine, Chicago, IL 1988-91; elected by Coast Counties Medical Society.

HOGAN, CHRISTOPHER D., Gulfport. Born State College, PA, April 19, 1965; MD Tulane University School of Medicine, New Orleans, LA, 1991; ophthalmology residency, Ohio State University Medical School, Columbus, OH, 1992-95; elected by Coast Counties Medical Society.

HUDSON, JEFFREY L., Hattiesburg. Born July 31, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1991; ob-gyn residency, University Medical Center, Jackson, MS, 1991-95; elected by South MS Medical Society.

JOHNSON, BRIAN P., Jackson. Born Saratoga Springs, NY, March 5, 1956; MD Medical College of Virginia, Richmond, VA, 1982; interned one year, Louisiana State University, Shreveport, LA; orthopaedic residency, Madigan Army Medical Center, Tacoma, WA, 1985-89; orthopaedic fellowship, University of Southern California, Los Angeles, CA 1992-93; elected by Central Medical Society.

JOHNSON, MARK V., Tupelo. Born Memphis, TN, July 3, 1964; MD University of Tennessee College of Medicine, Memphis, TN, 1990; radiology residency, University of Kentucky College of Medicine, Lexington, KY, 1990-94; diagnostic radiology fellowship, Bowman Gray School of Medicine, Winston-Salem, NC, 1994-95; elected by Northeast MS Medical Society.

JONES, GORDON S, Columbus. Born Starkville, MS, September 5, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; interned and orthopaedic residency, same, 1990-95; elected by Prairie Medical Society.

MALIAKKAL, ROY J., Jackson. Born India, May 12, 1963; MD St John's Medical College, Bangalore University, Bangalore, Mysore, India, 1986; internal medicine residency, State University of New York Medical Center, NY, & New England Hospital, Boston, MA; gastroenterology fellowship,
University Medical Center, Jackson, MS, 1993-95; elected by Central Medical Society.

MASTERSON, R. CALVIN, Vicksburg. Born Vicksburg, MS, July 20, 1966; DO Kirksville College of Osteopathic Medicine, Kirksville, MO 1992; family practice residency, University of Arkansas Medical Center, Pine Bluff, AR, 1992-95; elected by West MS Medical Society.

MCKENNA, MARGARET E., Hattiesburg. Born Chicago, IL, May 17, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1992; pediatric residency, same, 1992-95; elected by South MS Medical Society.

NEESE, LEWIS W., Hattiesburg. Born Florence, AL, March 29, 1959; MD University of Alabama School of Medicine, Birmingham, AL, 1989; internal medicine residency, Mayo Graduate School of Medicine Program, Rochester, MN, 1989-92; pulmonary medicine fellowship, Same, 1992-95; elected by South MS Medical Society.

PAYMENT, MICHAEL F., Jackson. Born Jackson, MS, August 21, 1956; MD University of Mississippi School of Medicine, Jackson, MS, 1983; internal medicine residency & cardiology fellowship, Same, 1983-95; elected by Central Medical Society.

PEDONE, JOSEPH A., Pascagoula. Born Colorado Springs, CO, September 28, 1952; MD Louisiana State University School of Medicine, New Orleans, LA, 1979; internal medicine residency, University Medical Center, Lafayette, LA, 1979-81; cardiology fellowship, Oschsner Foundation Hospital, New Orleans, LA, 1989-91; elected by Singing River Medical Society.

PERNIA, LUIS RONALD, Columbus. Born Stillwater, OK, September 21, 1949; MD Central University of Venezuela, Caracas, Venezuela 1976; interned and general surgery residency Lloyd Noland Hospital, Birmingham, AL 1978-83; plastic surgery, Tulane, Charity, Touro Infirmary, E. Jefferson Hospital, Baptist Hospital, Childrens Hospital, New Orleans 1983-85; elected by Prairie Medial Society.

PINSON, TERRY W., Tupelo. Born Oxford, MS, October 29, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; surgery residency, Carroway Methodist Medical Center, Birmingham, AL, 1990-95; elected by Northeast MS Medical Society.

POLCHOW, THURMAN NEAL, Pascagoula. Born October 13, 1955 in Phoenix, AZ; MD University of South Alabama College of Medicine, Mobile, AL, 1985; interned one year US Naval Hospital, San Diego, CA, ; radiology residency, University of South Alabama College of Medicine, Mobile, AL, 1990-94; elected by Singing River Medical Society.

RAY, MARK A., Tupelo. Born Memphis, TN, June 13, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1991; ob-gyn residency, same, 1991-95; elected by Northeast MS Medical Society.

ROBERTS, DAVID F., Diamondhead. Born Yazoo City, MS, August 16, 1957; MD University of Mississippi School of Medicine, Jackson, MS 1987; family medicine residency, University of Tennessee-Jackson Family Medicine Program, Jackson, TN, 1987-90; elected by Coast Counties Medical Society.

SINGH, M RAMESH, Laurel. Born India, December 10, 1953; MD

Chengalpattu Medical College, University of Madras, India, 1979; neurology residency, University Medical Center, Jackson, MS, 1992-95; elected by South MS Medical Society.

SULLIVAN, SABRA, Jackson. Born Jackson, MS, May 4, 1957; MD University of Texas Southwestern Medical School, Dallas, TX, 1988; interned one year, Parkland Hospital, Dallas, TX; dermatology residency Stanford Universtiy School of Medicine, Palo Alto, CA, 1989-92; elected by Central Medical Society.

TORP, ERIC C., Biloxi. Born Gary, IN, September 9, 1957; MD Indiana University School of Medicine, Indianapolis, IN, 1983; interned one year, Naval Hospital, Jacksonville, FL; dermatology residency Northwestern University School of Medicine, Chicago, IL, 1989-92; elected by Coast Counties Medical Society.

WALTON, WILLIAM T., Pascagoula. Born San Antonio, TX, February 4, 1960; MD Tulane University School of Medicine, New Orleans, LA., 1986; ophthalmology residency, University of Colorado School of Medicine, Denver, CO, 1988-91; elected by Singing River Medical Society.

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Personals

Alan E. Freland, MD, Professor of Orthopaedic Surgery, was the invited guest speaker for the 19th Annual Meeting of the Columbian Hand Society held in Bogota, Columbia, June 6-10, 1995. He was awarded Honorary Membership in the Columbian Hand Society and was given a Distinguished Visitors Medal.

J. T. (Jake) Davis, Sr. of Corinth, '74-'75 MSMA President, was writing a book *"Hand in Hand"* at the time of his death in 1994. Jo Barksdale, President of LeFluer's Bluff Publishing Company, has announced publication, *"Hand in Hand"* is more than a fascinating and often humorous account of Dr. Davis' life. According to Ms. Barksdale, "His predictions for the future of medicine and explanation of what has already happened with Medicare make it a very contemporary and timely book. Through Dr. Davis' exceptional story telling the "Golden Age of Medicine" is brought to life; from kitchen table surgery to medical practice during the days of house calls, when the doctor was considered a vital part of the family." **Dr. Alan E. Freland,** wrote the forward for **"Hand in Hand"** as follows: "As a surgeon, Dr. Davis loved hand and upper extremity problems. His interest was spawned and stimulated by his service in the European Theater of World War II, a war which birthed hand surgery as a specialty. Four years ago, with a vision to the future, he generously endowed the J.T. Davis Visiting Lectureship in Hand Surgery. Dr. J.T. Davis was truly Mississippi's pioneer hand surgeon. Following his directive, we will continue his work, advancing his high values and standards. In doing so we will be educating those people who will one day be his and our successors."

Editor's Note: Regretfully, Dr. and Mrs. J.T. Davis, Jr., were incorrectly identified in the July JOURNAL.

William B. Geissler, MD, Associate Professor of Orthopaedic Surgery at the University of Mississippi Medical Center, was invited to speak at the Arthroscopy Association of North America Instructional Symposium on Wrist Arthroscopy. Additionally, Dr. Geissler was an invited faculty at the Wrist Arthroscopy Course sponsored by the American Academy of Orthopaedic Surgeons. He spoke on "Functional Anatomy and Kinematics of the Wrist."

Louis A. Benoist, Assistant Professor of Orthopaedic Surgery at the University of Mississippi Medical Center in Jackson, won first place in the poster competition at the 6th International Federation of Societies of Surgery of the Hand held in Helsinki, Finland, July 3-7, 1995. The poster entitled, "The Treatment of Osteopenic Distal Radial Fractures with a Buttress Pinning Technique," was coauthored by Dr. Alan E. Freland.

John Marascalco, MD, and **Joseph Terracina, MD,** announce the arrivall of the new orion ktp/yag laser, a new and versatile laser and the only one of its kind in Missisippi to treat all of the following problems: facial blood vessels, sun/liver spots, red birth marks, pre-cancers, tatoos, moles and warts.

(continued on page 258)

Personals

(continued from page 257)

Michael E. Jabaley, M.D., of Jackson, Mississippi, has been elected president-elect of the American Association of Plastic Surgeons. Dr. Jabaley is in private practice in Plastic Surgery and a member of Plastic Surgery Associates, a five person group located at St. Dominic West Medical Tower. A Clinical Professor of both plastic and,orthopaedic surgery at the University of Mississippi Medical Center, Dr. Jabaley was elected in May at the annual meeting of the association in San Diego, California.

M. Gerald Lowrimore, MD, Ph.D., P.A., announces the association of **Joseph Anthony Proli, MD,** in the practice of Intervential Cardiology specializing in Cardiac Catherization, Angioplasty, Coronary Stents, Athrectomy, consultative Cardiology, Nuclear Cardiology, Endocardial Biopsy and Pacemaker Implantation.

Jorge E. Otero, MD, a University of Mississippi Medical Center resident, and his contributions to community service were recognized recently by the American Medical Association (AMA). Dr. Otero was one of 40 honorees of the AMA/ Burroughs Wellcome Co. Leadership Award Program for resident physicians. The AMA established the Leadership Program in 1988 with a grant from pharmaceutical manufacturer Burroughs Wellcome Co. Awardees from across the U.S. at'tended the AMA Resident Physicians Section Annual Meeting held June 15-18, 1995 in Chicago, Illinois. Dr. Otero will have the opportunity to attend the Interim Meeting in Washington, DC in December, 1995. The Leadership Program is designed to build ties between organized medicine and resident physicians who have displayed a commitment to community service. In Columbia, South America, Dr. Otero worked as a health provider and educator. He has also served as the medical student body liaison for the International Physicians for the Prevention of a Nuclear War. In this role he motivated, directed, and educated medical students worldwide about efficient non-hazardous energy waste disposal. As an internal medicine resident, Dr. Otero was asked to train Mexican American health care workers about HIV/AIDS prevention and to show them the programs implemented throughout Mississippi. The AMA/Burroughs Wellcome Co. Leadership Award Program will continue in 1996 and will honor residents nationwide.

Jeffrey L. Hudson, MD, has associated with the Hattiesburg Clinic in the practice of obstetrics and gynecology.

D. Melessa Phillips, MD, of Jackson has announced the formation of University Family Medical Associates in Jackson with the following locations-the West Jackson Family Medical Center, Lakeland Family Practice Center and the University Medical Pavillion. Dr. Phillips has been selected for inclusion in a new directory, Best Doctors in America: Southwest Region. Now in its second edition, the directory is "widely regarded as the preeminent referral guide to the medical profession."

Dr. Michael Brands, assistant professor of physiology and biophysics at the University of Mississippi Medical Center, has received the Marion Merrell Dow Young Scholars award from the American Society of Hypertension. He is the third member of the department to receive the award since its initiation in 1988. The new Dow scholar was cited, among other research accomplishment, for publishing the first data that suggested increased insulin per se was not responsible for hypertension associated with obesity and for showing that long-term blood pressure responses to insulin are species-specific.

Ronald Drabman, MD, professor of psychiatry and human behavior and director of the psychology residency program, at the University of Mississippi Medical Center and the Department of Veterans Affairs Medical Center announces that the program has been elected to receive the first Outstanding Training award to be presented in November by the Association for the Advancement of Behavior Therapy. This award recognizes the program's significant contributions to the field of behavior therapy in the area of training.

Joey Granger, MD, professor of physiology and biophysics at the University of Mississippi Medical Center, has been appointed to serve a three-year term on the cardio-renal grant review committee of the American Heart Association. The study section reviews grant applications related to cardiovascular and renal disease.

Stephanie Smith-Jefferson, genetics associate in the Department of Preventive Medicine at the University of Mississippi Medical Center

has been elected chair of the education committee of the Council of Regional Networks for Genetic Services (CORN). The council is composed of 10 regional genetic networks. Each CORN committee is made up of one representative from each network. Smith-Jefferson, the only genetic counselor in the state, also chairs the Southeastern Regional Genetics Group education committee and is the National Society for Genetic Counselors liaison to the CORN sickle cell, thalassemia and other hemoglobin variants committee.

Ted Woodrell, director of University Hospitals and Clinics at the University of Mississippi Medical Center, will be recognized at the American College of Healthcare Executives 61st annual meeting in August in San Francisco. Woodrell has completed requirements for recertification as a diplomate of the association by providing the credentials committee evidence of professional growth and competence.

Larry D. Field, MD, of Mississippi Sports Medicine and Orthopaedic Center, Jackson, presented two studies at the Arthroscopy Association of North America Annual Meeting in San Francisco entitled Arthroscopic Assessment of the Medial Collateral Ligament of the Elbow and Arthroscopic Anatomy of the Lateral Elbow: A Comparison of Three Portals. Dr. Field also recently participated as an instructor at a wrist arthroscopy course sponsored by the American Academy of Orthopaedic Surgeons in Chicago, Illinois.

F. H. Savoie, III, MD, of Mississippi Sports Medicine and Orthopaedic Center taught a two day course, Arthroscopy of the Shoulder, at Baylor University Medical Center in Dallas, Texas on June 20 and 21, 1995. Dr. Savoie presented four lectures on "Diagnosis and Management of Impingement Syndrome," "Evaluation and Treatment of Disorders of the Rotator Cuff", Arthroscopic Management of Instability of the Shoulder" and "Pathophysiology and Management of Adhesive Capsulitis of the Shoulder."

George Christopher Ball, MD, has fulfilled the requirements for the Physician's Recognition Award of the American Medical Association in Continuing Medical Education.

David Lee Sullivan. MD, and **Joseph F. Washburne, MD,** have opened the Tower Pavilion for Women in the practice of obstetrics and gynecology specializing in pregnancy and childbirth, mid-life women's health, women's surgery, infertility management and menopause.

Elizabeth McArthur Tibbs, MD, and **Robert C. Tibbs, II, MD,** have associated in the practice of pediatrics with Tibbs Clinic in Cleveland, Mississippi.

Suman Das, MD, F.A.C.S., F.R.C.S., F.R.C.S. (ED) has associated with the Street Clinic in Vicksburg in the practice of plastic and reconstructive surgery.

Audrey Tsao, MD, assistant professor of orthopaedic surgery, will evaluate an ultra high molecular weight polyethylene plastic for use in artificial hip and knee joints with $53,062 from Howmedica, Inc.

John B. O'Connell, MD, professor and chairman of medicine, spoke at the Congress of Yugoslav Society of Cardiology June 25-28 in Belgrade, Yugoslavia.

James L. Hughes, MD, chairman of orthopedic surgery, made a presentation at the American Orthopedic Association annual meeting June 10-13 in White Sulphur Springs, West Virginia.

E. Frazier Ward, MD, associate professor of Orthopedic Surgery was guest lecturer and instructor at the Unreamed Humeral Nail Documentation Series and Training in London, England.

Haynes Louis Harkey, MD, assistant professor of neurosurgery, taught a course and served as a faculty member at the International Spine Workshop in Bethesda. MD.

Jackson E. Fowler Jr., MD, professor of surgery and director of urology, served on an Advisory Committee for the World Organization for Benign Prostatic Hyperplasia and attended the third annual workshop on Benign Prostatic Hyperplasia in Monaco.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

Physicians' Recognition Award

Nineteen MSMA members were named recipients of the AMA Physicians Recognition Award in April 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
Frank W. Bowen, MD
Fred Houston Ingram, MD
George Rodney Meeks, MD

East Mississippi Medical Society
John Gilbert Alexander, MD

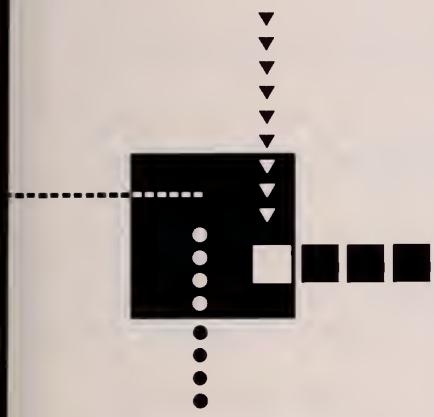
Northeast Mississippi Medical Society
Carl Chapman Welch, MD

South Mississippi Medical Society
Rodney Nicholson Lovitt, MD

Singing River Medical Society
Thurman Neal Polchow, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

Organized Medical Staff Section



Representation, Education and Networking

Twenty Sixth Assembly Meeting
November 30–December 4, 1995
Washington Hilton and Towers Hotel
Washington, DC

Send an AMA member physician representative from your hospital or health care delivery system to the 1995 Interim American Medical Association Organized Medical Staff Section (AMA-OMSS) Assembly Meeting to be held November 30 - December 4, 1995 in Washington, DC. Don't pass up this opportunity to participate in AMA's policy-making process and make a difference in the way your representative organization responds to managed care and other important issues facing today's physician. You can also gain valuable knowledge and make useful contacts by attending OMSS educational programs and networking functions.

With the growth of managed care, the merging of hospitals, and the corporatization of medicine, the traditional roles and responsibilities of the medical staff are being challenged. To help physicians respond effectively, OMSS's educational program titled, "Creating the Future and Getting There First," will focus on changing the medical staff paradigm, thinking in the future tense, and strengthening the physicians' leadership role in the governance of hospitals, integrated delivery systems, and managed care organizations. More specifically, the session will address:

- The changing environment and the value of self-governance;
- How to reengineer and improve medical staff functions and processes;
- The attributes of a successful self-governing physician organization (PO);
- The components of governance and resources needed to develop a community-based PO;
- What criteria should be utilized in making partnering decisions; and
- How to manage risk, respond to legal and logistical challenges, and raise capital.

For new insight into how to increase physician involvement in your community attend the AMA-OMSS Interim Assembly Education Program on Friday, December 1 from 2:30 pm to 5:30 pm in Washington, DC.

"The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians."

"The AMA designates this medical education activity for up to 3 credit hours in Category 1 of the Physician's Recognition Award."

For more information please call 800 **AMA-3211** and ask for the AMA's Department of Organized Medical Staff Services.

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For further information, please contact the North Mississippi Regional Center, Attn: Personnel, 967 Regional Center Drive, Oxford, Mississippi 38655.

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Cardiovascular Disease in Mississippi

Ellen S. Jones, MS
Amy D. Carr, MS

THE PROBLEM OF CVD

Cardiovascular disease (CVD), including all heart and blood vessel diseases, claims the lives of more Americans and more Mississippians than any other cause of death. CVD is the leading cause of disability, as well [1]. Coronary heart disease and cerebrovascular disease, or stroke, are the two most fatal types of CVD, as they are the first and third leading causes of death, respectively, in the U.S. [2] and in Mississippi [3]. In 1990, Mississippi's death rate of 247.8 (per 100,000 population) from all cardiovascular diseases was the nation's highest. In 1993, 11,895 people died from all cardiovascular diseases, comprising 45% of all deaths. CHD alone accounted for 36% of all deaths, while stroke caused seven percent of all deaths in the state[4].

Mississippi is classified as a "stroke belt" state on the basis of having an age-adjusted stroke death rate more than 10% higher than the national average. Ten of the 11 states fitting this criterion are in the southeast [5]. Years of Potential Life Lost, or YPLL, describes the years of life lost due to premature death from any cause. In Mississippi, in 1993, YPLL for heart disease and stroke combined was 61,516. Figures 1 and 2 show how the nine public health districts in the state compare in YPLL for heart disease and stroke [6].

THE ECONOMIC BURDEN OF CVD

Cardiovascular disease has a high economic price due to the direct costs of surgery, hospitalization, prescription drugs, and diagnostic tests. Indirect costs of lost productivity, absenteeism, disability pay, and reduced quality of life contribute to this economic burden.

CVD is the highest dollar component of health care expenditures and is the component that is increasing most rapidly. About 17% of the 900 billion dollars spent each year in the U.S. on health care is spent on CVD [7]. According to the Health Care Financing Administrations Medicare claims data, there were

approximately 150,000 Medicare admissions to acute care facilities in Mississippi during 1993. All CVD-related admissions by case, total charge, and average charge are described in Table 1.

Table 1 CVD-RELATED ADMISSIONS

CVD-RELATED ADMISSION	CASES	TOTAL CHARGE	AVERAGE CHARGE
Heart Disease	37,241	$ 313,060,770	$ 8,406
Coronary Bypass Surgery	998	$ 38,811,421	$ 38,889
Stroke	5,016	$ 39,971,601	$ 7,969
Pacemaker Surgery	924	$ 16,992,100	$ 18,390
Replacement Pacemaker Surgery	121	$ 1,648,593	$ 13,625
TOTAL	44,300	$ 410,484,485	-

Source: Mississippi Foundation for Medical Care, Inc., 1994

CVD RISK FACTORS

Major, modifiable risk factors for CHD include cigarette smoking, hypertension, high blood cholesterol, and physical inactivity. Contributing risk factors for CHD are diabetes, obesity, and stress. Additionally, poor nutrition can lead to or exaggerate the risk factors of high blood cholesterol, obesity, and diabetes. Existing CHD, hypertension, cigarette smoking, high red blood cell count, and transient ischemic attacks (TIAs) are major risk factors for stroke that can be controlled[8].

Heredity is a non-modifiable risk factor, in that some persons are genetically predisposed to CHD or stroke. Males have higher rates of CVD earlier in life, but women's rates dramatically increase after menopause. CVD affects older Americans more than any other disease[9].

CVD RISK SURVEYS

Behavioral Risk Factor Surveillance System

Adult Mississippians continue to be at high risk for developing some type of cardiovascular disease, as shown by the 1993 Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a random digit dialed telephone survey of health-related behaviors among adults aged 18 and over. When analyzed, the BRFSS identifies the populations in Mississippi that are at risk of developing a particular disease because of unhealthy lifestyles. The results from the BRFSS data are depicted in Table 2[10,11].

Table 2 CVD BEHAVIORAL RISK FACTORS AMONG MISSISSIPPIANS

RISK FACTOR	PERCENT
Overweight	36.3%
Current regular smokers	24.0%
High blood pressure	30.0%
High cholesterol	18.7%
Diabetes	3.6%
Sedentary lifestyle	68.0%

Youth Risk Behavior Survey

The health behaviors of the youth of Mississippi were measured in a separate survey, the 1993 Mississippi Youth Risk Behavior Survey (YRBS). Table 3 describes some of the results of that survey. Additionally, the majority of students had a high-fat diet, consuming foods such as french fries, hamburgers, and cookies on the average day[12].

Table 3 RISK BEHAVIORS AMONG MISSISSIPPI YOUTH

BEHAVIOR	PERCENT
Smoked in the past month	27.6%
Did not eat fruits	54.9%
Did not eat cooked vegetables	52.7%
Did not attend regular P.E. classes	78.4%

HEALTH PROMOTION TO PREVENT CVD

Demonstrated effective interventions of health promotion to prevent CVD have been performed at the worksite, schoolsite, and in the policy/legislative area. Health promotion programs in the worksite can significantly effect physical activity, blood pressure, stress, and smoking [13]. The National School Health Education Evaluation Study showed that health education can significantly change student's knowledge, attitudes, and health-related behaviors. Some controlled studies have even proven that school health can reduce the risk of children developing future heart disease [14]. Additionally, policies can have a notable impact on physical activity, smoking, dietary fat intake, stress, and weight control [15]. Interventions to prevent CVD are necessary in Mississippi and should be increased. Mississippi's current status of interventions to prevent CVD is expressed in the following findings.

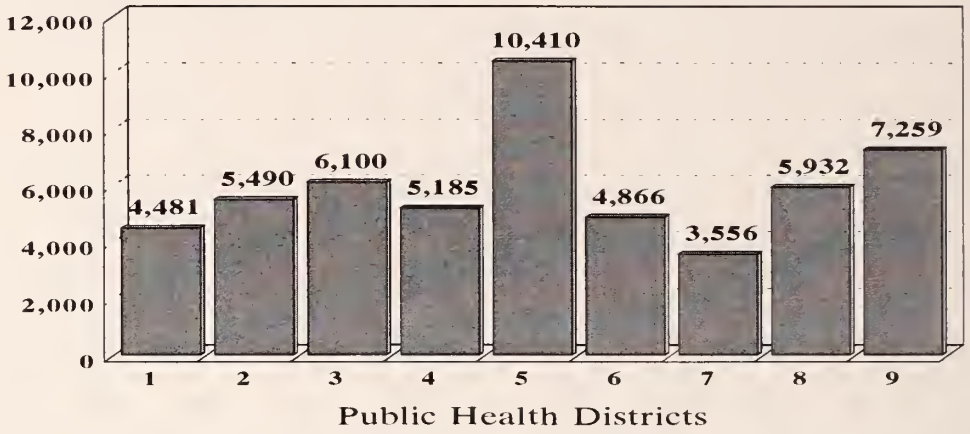
A worksite health promotion survey was conducted by Mississippi University for Women (.MUW) and the Mississippi State Department of Health (MSDH) [16]. It was distributed to Mississippi companies employing 250 or more people [17]. Nearly 53% of the 74 valid respondents indicated that they had some type of health promotion program or policy. Specific types of programs follow in Table 4.

Only five (6.75%) of these companies offered comprehensive risk factor education programs on hypertension, smoking cessation, fitness/exercise, and weight control/nutrition [18]. Nationally, 81% of companies offer worksite health promotion programs with at least one type of activity [19]. Healthy People 2000 states that worksites with 50 or more employees

Table 4 HEALTH PROMOTION IN MISSISSIPPI WORKSITES

TYPE OF PROGRAM/POLICY	PERCENT
Tobacco policy	66%
Drug-free workplace policy	83%
Seat belt use policy	49%
Alcohol, tobacco, and other drugs education	67%
Accident prevention, safety, first aid	82%
Smoking cessation	36%
Health risk assessments	36%
Fitness/exercise programs	36%
Hypertension screening/control programs	26%
Weight control/nutrition programs	26%

FIGURE 1: YEARS OF POTENTIAL LIFE LOST DUE TO HEART DISEASE
Mississippi Residents Aged 1 and Older



Total for Mississippi: 53,279

Source: Vital Statistics Mississippi 1993

that offer some form of health promotion activity should increase to 85% by the year 2000 [20].

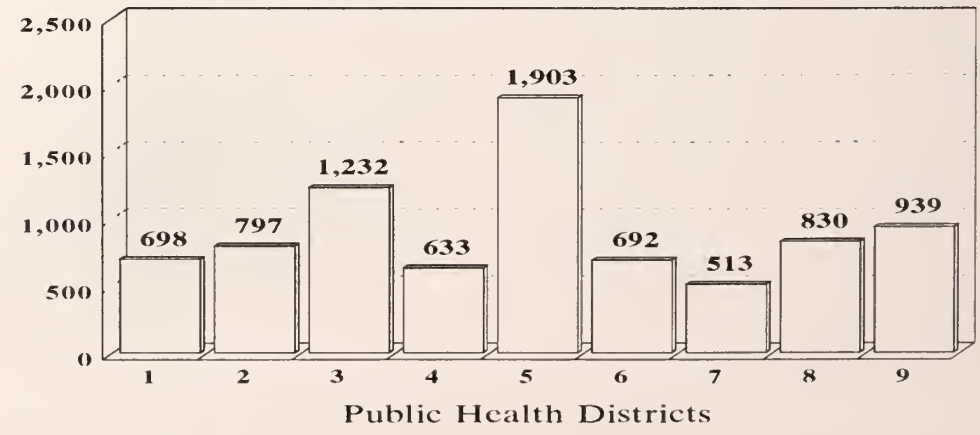
Mississippi is one of four states that does not have a law restricting smoking in public places. In 1992, the Tobacco Prevention Program at MSDH surveyed state agencies regarding smoking policies. Of 58 state agencies that responded to the survey, 44 had either a written or verbal no-smoking policy. Of those, 27 had a policy that restricted smoking to certain areas in the building, and 17 had a policy that prohibited smoking [21].

comprehensive health education in kindergarten through 12th grade, according to the Mississippi Department of Education (MDE). A strategic plan for comprehensive school health education written by MDE and MSDH is now in place.

DISCUSSION AND RECOMMENDATIONS

Mississippi is in the process of developing a state-based plan for preventing CVD modeled after "Preventing Death and Disability from Cardiovascular Diseases: A State-Based Plan for Action", developed

FIGURE 2: YEARS OF POTENTIAL LIFE LOST DUE TO STROKE
Mississippi Residents Aged 1 and Older



Total for Mississippi: 8,237

Source: Vital Statistics Mississippi 1993

by the Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPHE), the Association for State and Territorial Chronic Disease Program Directors (ASTCDPD), and the Association of State and Territorial Public Health Nutrition Directors (ASTPHND).

In order to develop population-based approaches to prevent and control CVD, health care providers and health promotion professionals should consider the following recommendations from the state-based plan for action:

1. Data: To monitor and distribute data on the burden of CVD and prevalence of risk factors.

Data sources include MSDH vital statistics, the BRFSS and YRBS, and data from the University of Mississippi Medical Center, the Mississippi Foundation for Medical Care, Inc., and the Office of Insurance of the Mississippi Department of Finance & Administration.

2. Policy and Legislation: To track policy and legislation related to CVD.

Examples include tobacco policies, school-based physical activity programs, comprehensive school health education, and physician training programs.

3. Public Awareness: To develop a public awareness campaign targeting modifiable behaviors in high risk groups. Included in dissemination of information should be county health departments, community health centers, churches, schools, and civic organizations.

4. Access to Services: To develop a state CVD plan that would include recommendations for health education, preventive health services, and access to control programs.

Key influentials such as community health center administrators, state medical and nursing associations, and public health officials should be involved in the development of the service plan.

5. Partnerships for Prevention: To develop community-based partnerships for the prevention of CVD.

Examples include schools, worksites, and voluntary agencies.

6. Accountability and Training: To insure standards for training health care providers, and public and community health educators.

Standards should include behavioral sciences, as well as practical experience in preventive medicine and health promotion. Colleges and universities should develop programs that mandate student involvement in community, school, worksite, and clinic-based programs to promote healthy lifestyles.

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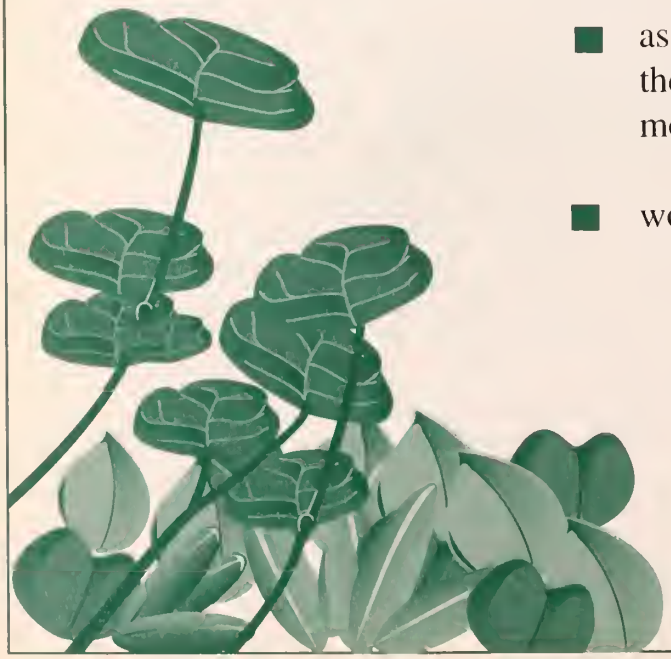
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Physical Therapy as an Effective Change Agent in the Treatment of Patients with Urinary Incontinence

Sylvia McCandless, MS, BS, PT
Ginger Mason, PT Affiliate Student, PTA

Among women with urinary incontinence, there is a widespread misconception that the problem is normal, irreversible, and a typical consequence of childbearing and aging. Research into this problem has found that incontinence is highly treatable with 50% of the cases having the ability to be cured, another 35% markedly improved, and the remaining 15% of patients made more comfortable through conservative treatment. (1) There are estimates that more than 1 0 million adults suffer from urinary incontinence at a estimated cost of 1 0 billion dollars a year in the United States alone. (2) Loss of bladder control is also cited as one of the most frequent reasons for nursing home admissions. (3) It is estimated that as many as 35% of women experience postpartum stress incontinence for 6-12 weeks after childbirth. (4) Unfortunately, due to a lack of information and education only 1 0% of people who suffer urinary incontinence seek out professional medical assistance. This discussion will be limited to urinary incontinence patents that can benefit from physical therapy intervention.

The muscles of the pelvic floor, primarily the levator sling, remain among the most complex and least understood muscle group. Experimental evidence suggests that one-third of the total intraurethral pressure is due to the striated muscles of the urethra and pelvic floor. (4) The levator ani through its connection to the endopelvic fascia provides support for the urethra, vagina and rectum as they descend through the pelvic floor. Because the levator ani are important to pelvic and urethral support (6), an exercise program could improve the support of the proximal urethra. The levator ani muscles contain both Type I (slow twitch) and Type 11 (fast twitch) muscle fibers making them capable of maintaining tone over a long period of time. They also have the ability to increase tone quickly to compensate for increased abdominal pressure that occurs with coughing, sneezing, or with exertion. (7) Increased control of both stress and urge incontinence is attainable through physical therapy intervention in the form of education and exercise.

Mixed incontinence accounts for at least 40% of incontinence in women. (8) This type presents with clinical features that include more than one of the major categories of stress and urge incontinence.

TREATMENT METHODS-HISTORICAL PERSPECTIVE

Arnold Kegel was the first person known to investigate and systematically strengthen the pelvic floor muscles. His method included a intravaginal exam and treatment to demonstrate to the patent an awareness of the pelvic floor muscles and encourage volitional contraction. He also instructed the patient

in the use of a perineometer pneumatic intravaginal device. This instrument functioned as a simple biofeedback device encouraging the patent to perform proper pelvic floor exercises. Kegel encouraged patents to exercise for twenty minutes three times per day and to record their progress in a daily chart. He used in the United States. A motivated patient and therapist are essential to the success of nonsurgical treatment. Physical therapy treatment consists of training the patent to recognize, perform and practice voluntary contraction of the muscles of the pelvic floor. The purpose of this is to build muscle strength and bulk in the pelvic floor musculature enough to support urethal closure during stress situations. Upon referral patents are given information about the pelvic anatomy and the purpose of pelvic floor muscle reeducation.

A vaginal exam can be performed by the therapist to help patents with awareness of the levator ani muscles, to evaluate the patients control of muscle contraction, and assign a muscle test grade. The manual muscle test grade will establish a baseline for goal setting and give an objective outcome measurement.

Maintaining a bladder diary is a useful technique that can allow patients to identify patterns of urination. These diaries can be an effective tool in assisting therapists to determine specific problems to address. The patient records fluid intake, urine output, number of accidental leakage episodes, amount and circumstances of the leakage, type of absorbent product used, and the activity being performed during the leakage. A bladder diary can measure progress in control, clarify the circumstances and percipitants of incontinence, and provide clues concerning possible behavioral interventions.

Physical therapy intervention includes various biofeedback devices from the most simple to very sophisticated machines; electrical stimulation; vaginal cones for resisted exercise; and education on diet, exercise, and bladder training. Biofeedback is an effective way to enhance training in women with genuine stress incontinence or an unstable bladder. Visual feedback displayed by a perineometer allows the patent to see a rise in pressure on a gauge. EMG biofeedback is also available which gives the patent cues on proper contraction of the pelvic floor muscles ruling out contraction of the abdominal and hip muscles. Electrical stimulation of the pelvic floor muscles helps the muscles to contract via an electrical current administered with a vaginal or rectal probe.

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Electrical stimulation is the modality of choice if the patent is unable to perform a significant contraction for using biofeedback or cones. Women with detrusser instability also benefit from functional electrical simulation. The mechanism of action is unclear, but the current effects the innervation of the bladder and urethra permitting improved bladder filling. Improvement in patients with urethral instability and overflow incontinence also has been noted. Units are available for home use.

Vaginal cones are identically shaped and progressively weighted from 20 to 1 00 grams. The regimen includes insertion and retention of the cones by contraction of the musculature of the pelvic floor. When a cone can be successfully retained while walking for 15 minutes, the next heaviest cone is used thereby progressively intensifying the required musculature exertion.

Women who suffer from urinary incontinence may find additional relief from a modification in diet. Foods are excluded that irritate the bladder. Also, a general exercise program is prescribed that promotes a healthy lifestyle.

Surgical treatment, such as urethral suspensions, have shown cure rates as high as 87%. (14) Physical therapy intervention pre- and post- operatively can provide education and exercise to enhance the success and longevity of the surgical repair. Studies have demonstrated that pre-operative education can: reduce post-operative complications; limit patent anxiety; decrease post-operative hospitalization; and, promote compliance of post-operative follow through care . (1 5,16,17) Urethral suspensions do not effect the strength of the pelvic floor muscles.

Research is needed to evaluate the effect on the longevity of successful surgical repair with increased strength of the pelvic floor muscles through a regimented exercise program.

In some documented research the outcome measures were greatest during the first eight weeks of physical therapy. When relating outcome of training in relation to duration, a number of women who were cured or whose condition improved increased with the duration of training. The minimum period necessary to obtain satisfactory results is three to four months. (18)

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CONCLUSION

From the survey of literature A is apparent that exercise programs to reeducate and rehabilitate the musculature of the pelvic floor do have a place in the prevention and treatment of urinary incontinence, not only for the nonsurgical candidate, but for the pre and post surgical patent as well. Considering the number of active women affected by

urinary incontinence, it is important to meet this challenge with a combination of strategies including modalities, exercise, and education to improve and even alleviate the problem.

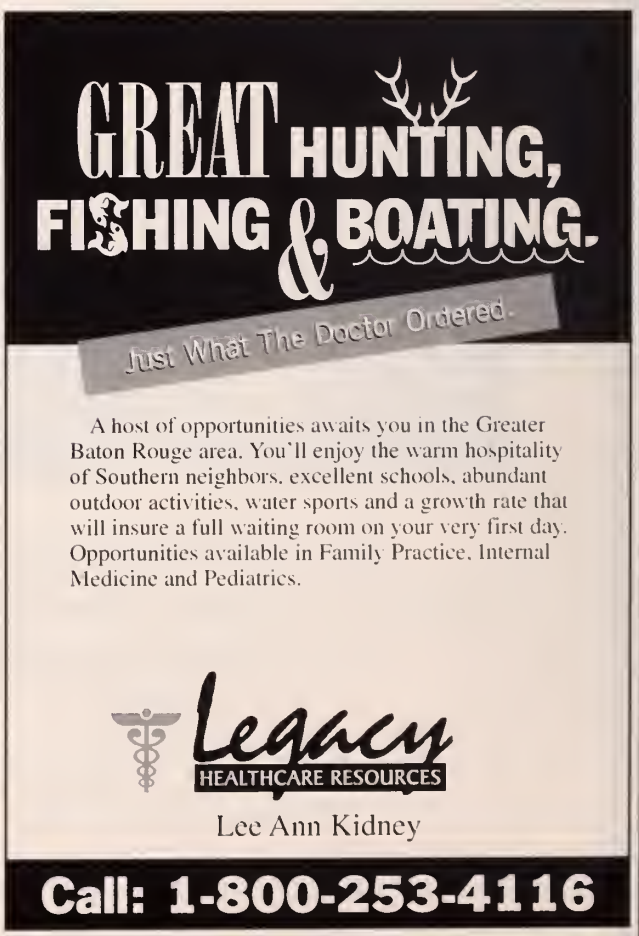
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D. Stanley Hartness, Jr., MD

The President's Page

You've Come A Long Way, Baby!

"More doctors smoke Camels than any other cigarette."
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From the 1940's ad featuring the distinguished cigarette-smoking physician to the recent no-holds-barred issue of JAMA (July 19) exposing previously undocumented tobacco industry activities, the medical profession has come a long way. The poignant interview with former tobacco lobbyist Victor Crawford, terminally ill with carcinoma of the tongue, served to put the unusual articles in dramatic perspective.

"It is in the interests of society to put the Pill into vending machines and to place cigarettes on prescription."
-Malcolm Potts

A recent newspaper article citing an increase in cigarette smoking among junior high students is even more disturbing when considered along with a subsequent report of a tobacco industry study targeting children as a potential market. World Health Organization

(continued on page 278)

AMA Applauds President's Call for Curbs on Teen Use of Tobacco

Statements attributable to:
Lonnie R. Bristrow, MD
President, American Medical Association

"President Clinton's announcement today marks an unprecedented leap forward in public health policy."

"The AMA has worked for years to bring the truth about tobacco's addictive, deadly nature to light. We are pleased that the President has recognized the danger tobacco poses to our children and has addressed the problem in a swift and serious manner."

"President Clinton has shown through his leadership and courage that the health of our children is a life and death issue."

"The tobacco industry prospers by addicting children to nicotine. Today, we've said: Our children's lives are worth more than the profit on a pack of cigarettes."

"For years the tobacco industry has misled us, withheld information and showed little regard for the sanctity of human life. Now, its time for them to face the music."

"Tobacco - like orange juice and aspirin - should be under the control of the FDA. We want to end the days of special treatment for the tobacco giants."

"We must not let the tobacco industry slow the progress of good policy by once again hiding behind a Berlin Wall of legal challenges. They must not be allowed to continue endangering the health and welfare of our next generation."

"We are hopeful that today we have turned an important corner in our battle against tobacco-related death and disease."

(President's Page continued from page 276)

statistics estimate that, of all beginning smokers who begin using tobacco in adolescence and continue smoking throughout their lives, half will be killed by **tobacco,** and half of those will succumb to a fatal tobacco-caused disease before age 70. If current smoking trends persist, 200 million to 300 million children and adolescents under 20 currently alive will eventually be killed by tobacco.

"When I was young, I kissed my first woman and smoked my first cigarette on the same day. Believe me, never since have I wasted any more time on tobacco." **-Arturo Toscanini**

By publishing the "massive, detailed, and damning" evidence of tobacco industry tactics as detailed in their own documents, the AMA has drawn the proverbial line in the sand. This bold stance reminds our patients, the politicians, and us that the mission of the AMA has been to "promote the science and art of medicine and the betterment of public health" and that opposition to the use of tobacco as well as eradication of tobacco-related disease is a pressing, nonpartisan public health issue.

"A custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and in the black, stinking fume thereof, nearest resembling the horrible Stygian smoke of the pit that is bottomless." **-James I**

The bottom line is that we must change the perception of cigarette smoking for our children and youth as "normal," with the aim of putting it "out of fashion."

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Editorials

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
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SEPTEMBER 1995

Mid-Life Crisis At Age Thirty

In July, 1965 congress passed Public Law 89-97, commonly known as the Medicare Act. The recent celebration of the thirtieth anniversary of medicare legislation was a major media event, and all of the various parties in Washington July noted this birthday. As I, reflected back and reviewed the history of this legislation I was impressed that this law was born in a political, crisis like atmosphere, has suffered through multiple changes and expansions, and is now experiencing a major mid-life crisis, and one is unsure of it's future or survival as we know it today. This history reflects the political influence on the origin, maintenance and future of the law,

The first national attempt to socialize health care occurred in 1937-38 shortly after passage of the Social Security Act. President Roosevelt resisted the idea as too radical and did not push for passage of this legislation. In 1949 Truman proposed passage of such legislation but this never reached the House or Senate. In the 1950 elections both houses of Congress were swept by conservatives with an anti-medicare sentiment. In 1957 Representative Aime Forand introduced the first medicare bill for persons over sixty five years of age and on social security. This attempt failed in the House. In 1960 the Kerr-Mills law extended an already existing program for needy persons.

In 1962 another attempt to pass medicare legislation was defeated because of lack of public support for the idea and the inability to generate public interest in the issue. As a result of that defeat the medicare atmosphere, in early 1963, was at it's lowest since the great depression and many considered it very clear that congress would never pass such legislation, primarily because of the lack of public interest and support.

Following that defeat the American Medical Association came forth with the Eldercare program proposal and presented this concept as an alternative to the medicare legislation. On November 21, 1963 Norman Welch, M.D. and Edward Annis, M.D. presented Eldercare to the House Ways and Means Committee, and received what they described as very strong support for the program.

The cataclysmic event of November 23, 1963 in Dallas, Texas brought about changes which profoundly altered the atmosphere in Washington, with ripple effects leading to ultimate passage of the Medicare law. First the Senate passed an amendment proposing such legislation, however, this never passed the House. The Washington scene changed more dramatically after the 1964 elections. Many argued that the election constituted a mandate calling for passage of both welfare legislation and increased centralization of government. In a speech in Little Rock, Arkansas on December 2, 1994 Wilbur Mills, chairman of the Ways and Means Committee reversed his previous opposition and openly supported the medicare concept. In opposition to great public support for the eldercare proposal by the AMA, and apathy for the Medicare proposal, the House Ways and Means Committee presented an omnibus bill which had been developed behind closed doors, in cooperation with the Secretary of Health, Education and Welfare. This subsequently became Public Law 89-97 in July, 1965. In conjunction with

(continued on page 280)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(continued from page 279)

passage of the Medicare law proponents of Title XIX of the Social Security Act worked diligently to expand that act to include all people.

Passage of this law brought mixed responses from medicine, politicians and the public. On June 26, 1966, in a speech before the Conference of Presidents stated," I want to pay the doctor bill myself", "I want the doctor to feel he is working for me". As history reflects, this sentiment was not shared by many others in Washington and throughout the country. Socialization of the health care system was here to stay.

In August, 1966, Scholten, Rubin and Lewis published the results of a poll of 1500 medical students on the predicted effects of Medicare on the practice of medicine (JAMA Aug 1, 1966, vol. 195, page 111-113). It is very interesting to retrospectively review the insightful results of that poll. The majority of respondents predicted that:

1- the patient-doctor relationship would decrease,
2- the use of medical facilities would greatly increase,
3- charity care rendered by physicians would greatly decrease,
4- the standards of medical care would decrease,
5- physicians would divide into two groups, those affiliated with hospitals and those continuing in private practice,
6- a marked increase in super-specialist would occur.

As we know all of these predictions have proven true.

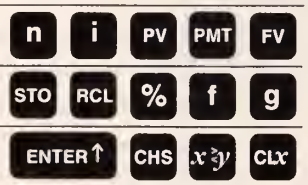
Following the difficult birth of PL 89-97 regular changes to the law have greatly expanded the original concepts of that legislation. Each successive Congress has done it's share in expanding the list of eligible persons as well as the benefits offered. Unfortunately these politically motivated changes have now placed the entire program in a severe mid-life crisis at the early age of thirty years. Currently one cannot determine from the quagmire of proposals and the political atmosphere in Washington if this crisis can be surmounted and a feasible program continue.

Myron D. Lockey, MD
Editor

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Delegate's AMA Report
1995 Annual Meeting of the House of Delegates

Introduction

The AMA House of Delegates met in Chicago, June 18-22, 1995.

The House is composed of 432 voting delegates, representing state medical associations, national medical specialty societies, AMA Sections, the Armed Forces, and the U.S. Public Health Service.

The House agenda contained 87 reports and 233 resolutions.

Mr. Newt Gingrich, Speaker of the U.S. House of Representatives, spoke to and answered questions on Medicare reform from the House of Delegates via a live satellite hookup.

The House considered many diverse issues in socio-economics, science, medical education and public health. Following are the highlights of the major issues considered at the meeting:

Medicare Transformation

The Board of Trustees submitted a comprehensive report reviewing the current status of the Medicare transformation debate, outlining current strategy and policy approaches on this issue, and recommending policy changes to enhance advocacy efforts in this important legislative initiative.

The House of Delegates was clearly focused on the political debate surrounding the restructuring of the Medicare program to avoid the looming financial crisis. The Board stated that "Medicare must be transformed by reducing the growth rate of program expenditures and by fully funding its promise to beneficiaries. These goals cannot be met through failed policies of the past. They must be achieved through shared sacrifice." The AMA's goals are to:

(continued on page 282)

(continued from page 281)

1. Enhance personal responsibility and cost consciousness.
2. Enhance intergenerational equity in financing.
3. Enable and facilitate price competition among providers.
4. Reduce regulatory and administrative complexity.

The House of Delegates debated this issue extensively, both in the Reference Committee and on the House floor, amended the Board's recommendations and adopted the following policy statements to guide the Association during the course of this legislative battle:

1. That the AMA reaffirm that the fundamental goal of transforming Medicare should be to assure the health of the elderly and disabled populations. Patients must have access to high quality medical services. The best value in medical care can be achieved by ensuring that the medical profession has a central role in the design and implementation of a new Medicare program. Patients must also receive timely and accurate information on the necessity and important aspects of Medicare transformation.

2. That, in the context of changes that enhance the fiscal solvency of Medicare, increase beneficiary choice, and encourage program privatization, AMA policy should accept a defined contribution by the federal government toward the purchase of private health care coverage by Medicare beneficiaries. This defined contribution should equal the national average risk adjusted actuarial value of the government Medicare contribution for individuals retaining traditional Medicare coverage. The value of this contribution should reflect the cost of access to needed health care, including preventive services, and the need to establish the fiscal solvency of Medicare.

3. That AMA policy should include approaches that restructure Medicare beneficial deductibles, coinsurance, premiums, and Medigap insurance to enhance the effectiveness of cost sharing, increase patient choice, maintain beneficiary financial protection, and reduce costs to Medicare and beneficiaries from Medigap coverage. This restructured cost sharing should include appropriate incentives for patients to seek and receive preventive services,

4. That, consistent with current AMA policy, Medicare should eliminate price and regulatory controls on charges and payments, including limiting charges for physicians' services and the flawed Medicare Volume Performance Standard. Consistent with current policy, these controls would be replaced by a competitive pricing system in which physicians would set and disclose to patients their own fees and/or dollar conversion factor for the RBRVS and Medicare would set its conversion factor, considering both the budget and patient access to care. A similar approach should be implemented for Part A of Medicare.

5. That, current policy on Medicare funding of graduate medical education be replaced to state, "In the context of an all-payor funding pool for graduate medical education, Medicare contributions for direct and indirect costs of graduate medical education should be reduced consistent with the need to improve Medicare fiscal solvency and with the provision that these funds be replaced, in aggregate, with contributions from the all-payor funding pool sufficient to maintain adequate funding for graduate medical education." Moreover, the all-payor funding pool should be administered by a public-private sector partnership.

6. That AMA policy should accept a gradual reduction in the number of PGY1 resident positions funded through the Medicare direct and indirect medical education adjustments.

7. That, consistent with existing policies, patient and physician interests in high-quality care should be protected through non-intrusive regulatory approaches and existing or enhanced private sector efforts.

8. That the Board submit a progress report on Medicare transformation, providing details on mechanisms and criteria by which the Medicare defined contribution would be established initially and updated over time to

take into consideration patient access, changing demographics, and the effect of inflation.

Medicaid

The House considered two resolutions regarding legislative proposals to reform the Medicaid program by turning it into a Block Grant Program. The House adopted a substitute resolution that called on the AMA to:

1. Seek to assure that any restructuring of Medicaid, including block grants, preserve the safety net function of Medicaid.

2. Seek to identify and support alternatives that promote flexibility and innovation in the Medicaid program, such as programs allowing individuals to buy-in to Medicaid on a sliding scale based on income level, while ensuring quality and improving access to health care services.

The Criminalization of Health Care Decisionmaking

Two resolutions were introduced regarding the current trend among courts and state legislatures to attempt to criminalize health care decisionmaking. The House adopted a substitute resolution asking the AMA to:

1. Oppose the attempted criminalization of health care decisionmaking especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public.

2. Develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decisionmaking, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decisionmaking.

Professional Liability

The House heard testimony highlighting the need for federal professional liability reforms that would: (1) establish a cap on liability awards and (2) preempt state laws or regulations that prohibit such a cap. However, the testimony recognized the equally compelling need to protect existing or future state caps on liability awards which are lower or more comprehensive than those enacted on the federal level.

The House adopted a substitute resolution calling on the AMA to:

1. Support professional liability reform on the federal level that will preempt state constitutional, statutory, regulatory and common laws that prohibit a cap on liability awards.

2. Support federal legislation which shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation.

Tort Reform and the Tobacco Industry

In a related action the House adopted a policy asking the AMA to: Oppose any provision of tort reform legislation that would give exclusion from liability or special protection to tobacco companies or tobacco products.

(continued on page 285)

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Needs: Full-time

Alabama

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Needs: Full-time

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Needs: Part-time

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For Further Information

(continued from page 285)

Physician Assistants and Nurse Practitioners

The Board submitted a report that reviewed the professional relationships of physicians with nurse practitioners and with physician assistants with respect to AMA policy, definitions, and the views of other organizations. The House revised the model guidelines and adopted suggested guidelines for physician/physician assistant practice. (Action of the House is attached in its entirety).

Mandatory Rating System for Content of Musical Lyrics and Videos

One resolution, cosponsored by the Florida and Montana delegations, received wide media coverage. The resolution pertained to certain music that is popular with a significant portion of the younger population that is characterized by inflammatory lyrics that denigrate women as well as promote and incite violence, brutality and aggression.

The House adopted a substitute resolution directing the AMA to:

1. Continue to publicly express concern about the potentially negative impact that destructive themes depicted in the lyrics of certain music may have on the nation's youth.

2. Reaffirms existing policy which expresses concern about themes in some musical lyrics, encourages physicians and parents to be aware of possibly destructive themes in some music.

3. Offer to work with the music recording industry to develop a mandatory-rating system.

Food and Drug Administration

The House considered an informational report from the Board and four resolutions on various proposals to reform the Food and Drug Administration. Many delegates commended the FDA for keeping unsafe and ineffective medical products from being marketed. Others spoke about the length of time required for a drug to be approved.

The Board report was amended by the addition of three policy statements that read as follows:

1. That the AMA reaffirm its policy to continue to monitor and evaluate proposed changes in the FDA and to respond as appropriate.

2. That the AMA continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA.

3. That the AMA continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers, pharmaceuticals, and devices to try to resolve the concerns of physicians and to support the FDA initiatives of potential benefit to patients and physicians.

4. That the AMA continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively.

Opposition to Payment for Prescription-Switching

A resolution, introduced by the South Dakota Delegation, addressed the issue of pharmaceutical companies notifying pharmacists that they will pay to the pharmacist a fee to provide counseling services regarding their

(continued on page 287)

Physicians Capital Source

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product, causing patients to ask their physicians to change their prescriptions to one recommended by the pharmacist. In turn, the pharmacist receives a counseling fee from the pharmaceutical company.

The House of Delegates adopted a substitute resolution strongly denouncing this practice, calling on the AMA to:

1. Reaffirm policies which oppose the practice of therapeutic substitution by pharmacists.

2. Denounce the practice of pharmacists recommending to patients that prescriptions be changed to products manufactured by companies which pay pharmacists upon completion of such prescription-switching.

3. Denounce the practice by companies of offering payments to pharmacists in exchange for recommending changes in prescriptions.

4. Reaffirm current policy which opposes the practice of prescription-switching for payment by pharmacists.

5. Denounce the practice of medicine by pharmacists.

6. Notify the American Pharmaceutical Association (APhA) of these actions and encourage the APhA to adopt similar policies.

Point of Service

The Council on Medical Service submitted a comprehensive report entitled, "Health Benefits Plans and 'Point of Service'" that reviewed current policy that provided a basis for the AMA's Patient Protection Act and recommended a policy change. The modification would clarify the Council's original intent and current belief that all health plans or sponsors of such plans that restrict patient choice should be required to offer an optional Point of Service feature at the time of enrollment and, at least, for a continuous one-month period annually thereafter.

The House adopted the Council's recommendation and asked the AMA to review available data on the cost of options for point of service and evaluate the necessity for an AMA sponsored study of the costs of options for point of service and report back to the House at the 1995 Interim Meeting.

Conclusion

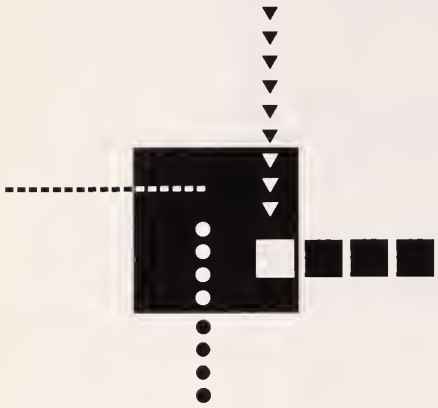
AMA House meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the AMA may present testimony at the Reference Committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

If you cannot come to the meeting, you can still be represented through your delegate. Let your delegation know your opinion. You can also prepare a resolution and request that it be submitted to the AMA House of Delegates. Your delegates know how to best carry forth your point of view.

DELEGATES	ALTERNATE DELEGATES
Sidney Graves, M.D., Natchez	George E. McGee, M.D., Hattiesburg
J. Edward Hill, M.D., Tupelo	Candace E. Keller, M.D., Hattiesburg
James C. Waites, M.D., Laurel	W. Lamar Weems, M.D., Jackson
J. Elmer Nix, M.D., Jackson	Michael H. Carter, Jr., M.D., Greenwood
William C. Gates M.D., Columbus	H. Vann Craig, M.D., Natchez
Don Q. Mitchell, M.D., Jackson	Richard C. Miller, M.D., Jackson

Organized Medical Staff Section

Twenty Sixth Assembly Meeting
November 30–December 4, 1995
Washington Hilton and Towers Hotel
Washington, DC



Representation, Education and Networking

Send an AMA member physician representative from your hospital or health care delivery system to the 1995 Interim American Medical Association Organized Medical Staff Section (AMA-OMSS) Assembly Meeting to be held November 30 - December 4, 1995 in Washington, DC. Don't pass up this opportunity to participate in AMA's policy-making process and make a difference in the way your representative organization responds to managed care and other important issues facing today's physician. You can also gain valuable knowledge and make useful contacts by attending OMSS educational programs and networking functions.

With the growth of managed care, the merging of hospitals, and the corporatization of medicine, the traditional roles and responsibilities of the medical staff are being challenged. To help physicians respond effectively, OMSS's educational program titled, "Creating the Future and Getting There First," will focus on changing the medical staff paradigm, thinking in the future tense, and strengthening the physicians' leadership role in the governance of hospitals, integrated delivery systems, and managed care organizations. More specifically, the session will address:

- The changing environment and the value of self-governance;
- How to reengineer and improve medical staff functions and processes;
- The attributes of a successful self-governing physician organization (PO);
- The components of governance and resources needed to develop a community-based PO;
- What criteria should be utilized in making partnering decisions; and
- How to manage risk, respond to legal and logistical challenges, and raise capital.

For new insight into how to increase physician involvement in your community attend the AMA-OMSS Interim Assembly Education Program on Friday, December 1 from 2:30 pm to 5:30 pm in Washington, DC.

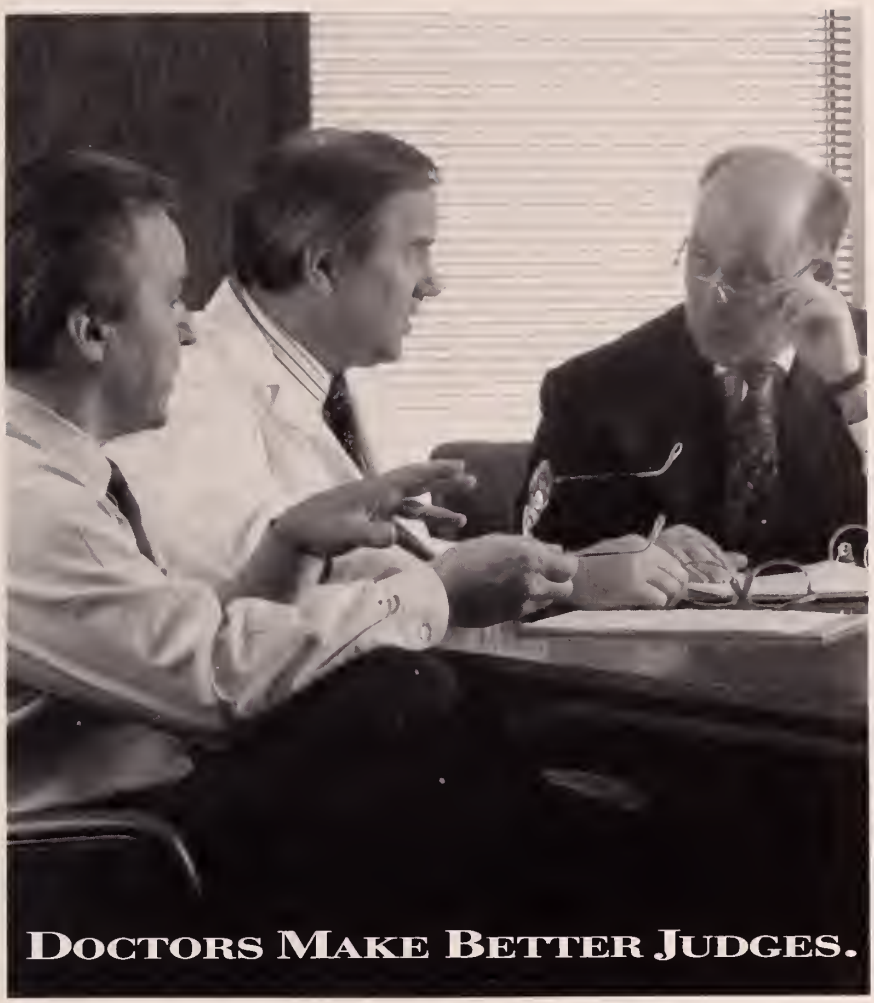
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Mississippi Foundation For Medical Care

Quality Improvement Projects

The primary goal of the Foundation's Quality Improvement Projects is to improve the care and outcomes for Medicare beneficiaries. This goal is accomplished through the collection of data, analyzing and comparing patterns of care to practice guidelines, and finally feeding the data back to the hospitals where the Medicare beneficiaries are treated.

The hospitals and medical staffs, in collaboration with the Foundation, will then identify specific areas for quality improvement in processes or outcomes of care and develop and carry out interventions to achieve these improvements.

Hospitals will participate in improvement projects at varying levels for a wide array of reasons.

If a provider does not wish to participate, the Foundation will attempt to determine the reason for this decision. Additional assistance from the Foundation may be needed, possibly in the form of more information or better communication; examples of successful improvement plans from other institutions; or special technical assistance/expertise otherwise unavailable to the provider.

Other possible reasons for deciding not to participate in a project in response to project data provided by the Foundation include:
*Projects or need for improvement in other high priority areas;
*The hospital data may not look that bad in comparison to peers;

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*The presence of some root cause acting as a barrier toparticipation, i.e., the hospital may think the problem is too complex and/or would involve in-depth statistical analysis beyond their capabilities or use of Continuous Quality Improvement (CQI) tools, whereas the Foundation could suggest a simpler, more straightforward approach or could offer additional resources/expertise to the hospital; or

*The hospitals need to see progress at other institutions or from other Foundation projects prior to the commitment to participate in a cooperative project.

These reasons for non-participation are not all-inclusive. Rather, they represent some examples of why institutions may be unwilling to join with the Foundation in cooperative improvement projects.

The Health Care Financing Administration (HCFA) does not require all hospitals to participate in projects, but rather to encourage hospitals to utilize the Foundation's unique ability to provide comparative data analysis and to consider the benefits and value of the principles of CQI before dismissing any improvement efforts.

The Foundation is seeking ways to understand the needs and ways it can support local improvement projects with all providers. The objective evaluation of its own communication strategy in order to determine if there is room for improvement is necessary. The Foundation also seeks input from institutions which have active quality improvement programs with demonstrated results in order to learn from their examples and determine where there are opportunities for partnerships.

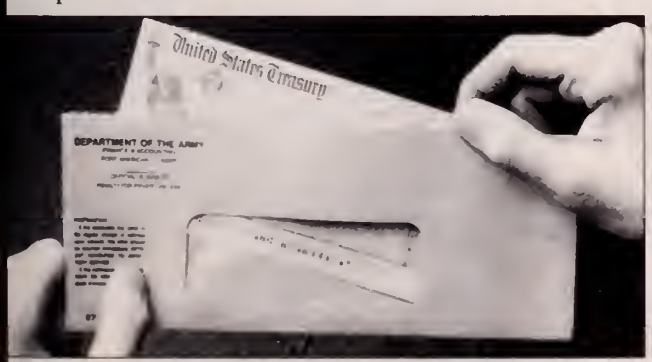
Throughout the state, we hope that we will be able to identify opportunities for improvement and stimulate hospitals and medical staffs to design and conduct improvement activities. Then we will succeed in our important health quality improvement role for Medicare.

The Foundation solicits any suggestions and is studying the possibility of forming a task force to study this process of developing quality improvement projects and plans at the hospital/medical staff level. For further information, contact Dr. James S. McIlwain or Dr. Alton B. Cobb at the Foundation of-

James S. McIlwain, Jr., MD
Foundation Medical Director

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Dr. Vinod K. Anand (surgery), Dr. Tawfig Khansur (medicine), and **Dr. William H. Replogle (family medicine)** were promoted to the rank of professor in the medical school at the University of Mississippi Medical Center.

University of Mississippi Medical School faculty appointed to associate professor included **Dr. Luiz Germano Reblin DeLima (anesthesiology), Dr. John J. Donaldson (pediatrics), Dr. Harriette L. Hampton (ob-gyn), Dr. Suzanne Miller (pediatrics), Dr. Frank A. Raila (radiology), Dr. Bruce R. Parks (pediatrics), Dr. Russell S. Tarver (medicine), Dr. Audrey K. Tsao (orthopedic surgery), Dr. Jennifer E. Hamrick-Turner (radiology), Dr. Vettaikorumakankav V.**

James D. Fly announces the formation of Mississippi Retina Associates, P.A.and the association of **Michael J. Borne** for the practice of Opthalmology, limited to Retina and Vitreous.

Larry D. Field of Jackson recently served as an instructor at the course Wrist Arthroscopy: Current Perspectives sponsored by the American Academy of Orthopaedic Surgeons. Also, Dr. Field recently presented two talks at the Arthroscopy Association of North America's annual meeting in San Francisco entitled "Arthroscopic Assessment of the Medial Collateral Ligament of the Elbow" and "Arthroscopic Anatomy of the Lateral Elbow: A Comparison of Three Portals."

Dr. Robert L. Galli, associate professor of emergency medicine, has been named chairman of the Department of Emergency Medicine at the University of Mississippi



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AIR FORCE

Physicians' Recognition Award

Nineteen MSMA members were named recipients of the AMA Physicians Recognition Award in August 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
Frank W. Bowen, MD
Fred Houston Ingram, MD
George Rodney Meeks, MD

East Mississippi Medical Society
John Gilbert Alexander, MD

Northeast Mississippi Medical Society
Carl Chapman Welch, MD

South Mississippi Medical Society
Rodney Nicholson Lovitt, MD

Singing River Medical Society
Thurman Neal Polchow, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

PHYSICIAN

The North Mississippi Regional Center is currently seeking a Physician for the Medical Services Division. The North Mississippi Regional Center is a 285 bed mental retardation facility operated by the Mississippi Department of Mental Health. The facility is located in Oxford, Mississippi, home of The University of Mississippi and approximately a one (I) hour drive 0 from Memphis, Tennessee.

For further information, please contact the North Mississippi Regional Center, Attn: Personnel, 967 Regional Center Drive, Oxford, Mississippi 38655.

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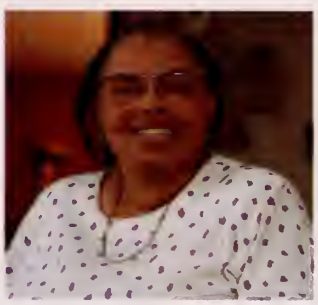
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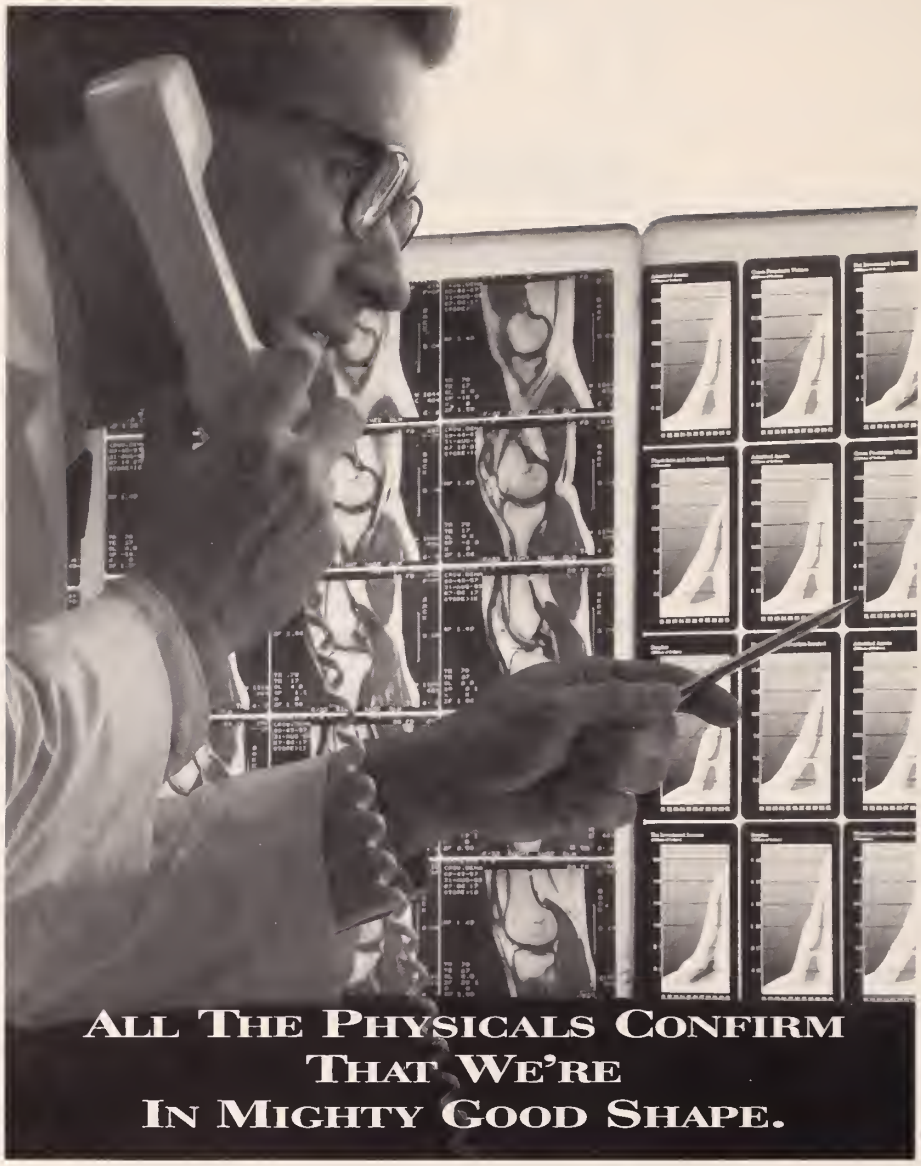
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Adolescents as Victims of Family Violence

Council on Scientific Affairs
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Adolescents experience maltreatment at rates equal to or exceeding those of younger children. Recent increases in reported cases of maltreatment have occurred disproportionately among older children and adolescents. However, adolescents are less likely to be reported to child protective services and are more likely to be perceived as responsible for their maltreatment. Adolescent girls are reported as victims more often than boys, especially in sexual abuse. However, boys may be less likely to be identified or reported and often are abused by nonfamily members. Parents of adolescent victims have higher average income and educational levels and are less likely to have a parental history of abuse than parents of younger children. A wide range of serious adolescent risk behaviors is associated with maltreatment. These include increased risk of premature sexual activity, unintended pregnancy, emotional disorders, suicide attempts, eating disorders, alcohol and other drug abuse, and delinquent behavior. Incarcerated youth, homeless or runaway youth, and youth who victimize siblings or assault parents have been shown to have high rates of prior maltreatment. Signs of maltreatment are often ambiguous for adolescents. Screening questions have been effective in prompting self-disclosure of abuse. Adolescents also experience problems in the child welfare system that offers fewer and less appropriate services for this age group. Recommendations are made regarding screening of adolescents for maltreatment, the development of better services for adolescents, research on parenting to prevent maltreatment, and training of school staff to identity and refer victims of maltreatment.

In the last decade there has been increased recognition of family violence and child maltreatment as problems that affect adolescents as well as younger children. Results of two national studies of child abuse and neglect indicate that recent increases in the number of reported cases of maltreatment have occurred disproportionately among older children and adoles-

cents. The overall incidence of abuse and neglect in adolescents is either higher or the same as that of younger children. While most fatal abuse occurs among younger children, moderate injuries are more prevalent among older children and adolescents. Further risk-taking behaviors in, reaction to abuse may result in serious health problems or deaths.

Diagnostic and treatment guidelines concerning child abuse and neglect have been published by the American Medical Association (AMA),[1,2] the American Academy of Pediatrics,[3] and the American Academy of Child and Adolescent Psychiatry.[4] However, none of these have separated early childhood issues from those pertinent to adolescents. The American Academy of Pediatrics has guidelines on the physician's role in rape cases that are specific to adolescents.[5] Identification of adolescent maltreatment victims is medically important because youth with a history of victimization are more likely to engage in a variety of health risk behaviors[6-11] and are more likely to be future victims or perpetrators of family violence.[12,13] This article will examine the prevalence of adolescent maltreatment, describe factors distinguishing adolescent victims and younger victims, and make recommendations for identification and referral of adolescent victims. The article will focus on the physical and sexual abuse of adolescents since the most research is available on these types of maltreatment.

MEASUREMENT OF ADOLESCENT MALTREATMENT

Estimates of the prevalence and incidence of adolescent maltreatment vary depending on the age used to define adolescence, the definition of abuse or neglect, and the measurement used. Unless otherwise specified in this article, adolescents will be defined is persons between the ages of 12 and 17 years. The term maltreatment will be used to refer to cases of both abuse and neglect.

Definitions of maltreatment vary widely. The National Center on Child Abuse and Neglect (NCCAN)[14] offers the following definitions for the major types of maltreatment:

- *Physical abuse.* Physical acts that caused or could have caused physical injury to the child .
- *Sexual abuse.* Involvement of a child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, prostitution, pornography, or other sexually exploitative activities.
- *Psychological* or emotional abuse. Acts or omissions that caused, or could have caused, conduct, cognitive, affective, or other mental disorders.
- *Neglect.* Failure to provide needed, age-appropriate care.[14]

Most studies use definitions that further specify the types of acts considered abusive for each type of abuse, although this also varies across studies and by state for official reports. For example, sexual abuse typically includes fondling of nongenital body parts, molestation with genital contact, and heterosexual and homosexual acts. Physical abuse includes any act in which physical injuries are inflicted by punching, beating, kicking, biting, burning, or otherwise harming a child. Hitting with an object may also sometimes be defined as an abusive act. Intention to hurt the child is not necessary; the injury may occur during punishment that is excessive or inappropriate to the child's age.

For children of any age, accurate estimates of the incidence of maltreatment are difficult to obtain. Estimates using self-reports of abuse from social surveys or officially reported cases are likely to underestimate the incidence of maltreatment due to reluctance by victims to admit the occurrence of abuse and the likelihood that many cases are not identified or reported. Adolescents are even less likely to be identified because they typically incur less serious physical injuries than younger children and so are less likely to require medical care or be identified as abuse victims when care is sought. Also, adolescent victims are more likely to be served by alternative youth-serving agencies, such as runaway centers, which are not surveyed for off icial reports" and may not report abuse to child protective agencies due to beliefs that appropriate services for Adolescents are not available.[16] One study[16] found that only 39% of the adolescent maltreatment cases were reported to child protective agencies compared with 76% for younger children.

Variations in state and local practices in reporting or substantiating reports of maltreatment also contribute to underestimates of the number of adolescent victims. Substantiated cases are those in which a child protective service agency finds enough evidence to prove that maltreatment has occurred. Cases may fail to be substantiated because a youth shows no physical injuries or recants his or her disclosure, both of which occur frequently for adolescents. Failure to substantiate does not always indicate that no maltreat-

ment occurred. Finally, when adolescents are abused by nonfamily members, these cases are riot handled by child protective services and therefore not included in official reports.

PREVALENCE AND INCIDENCE OF MALTREATMENT OF ADOLESCENTS

Data on the prevalence of adolescent maltreatment are derived primarily from several major surveys and from several small-scale studies involving clinical, populations of identified or suspected cases of adolescent maltreatment. The major surveys include the following:

- Two studies, referred to as the National Incidence Studies (NISs), conducted by NCCAN. Estimates are based on official reports collected from a 29-county sample of child protective and social service agencies, children's hospitals, mental health centers, juvenile probation departments, public health departments, schools, and police departments. The first study referred to hereafter as the NIS-1980[17] included cases reported in a 12-month period from 1979 to 1980. The second study, NIS-1988,[15] reported cases collected in a 3-month period during 1986. Summary data of child abuse reports to state child protective service agencies were also collected by NCCAN in 1990.[14]
- Tabulations of cases of maltreatment reported to 40 state child protective service agencies compiled by the American Humane Association.[18] Data were collected annually between 1976 and 1987.
- Two studies of domestic violence using self-reports from national probability samples conducted by Straus and Gelles in 1975 and 1985.[19] These studies are referred to hereinafter as the first and second National Family Violence Surveys (NFVSs).
- Estimates of maltreatment broken down by state and type of abuse that were collected by the National Committee for the Prevention of Child Abuse annually since 1985 as part of their Annual Fifty State Survey.[20]

The most recent available data from the Annual Fifty State Survey[20] indicated that in 1991 more than 2.5 million cases of child abuse were reported to child protective service agencies. This represents a rate of 42 cases of maltreatment per 1000 children. All surveys using official reports showed an increase in the number of reported cases of abuse between 4980 and 1991.[14]

Adolescents comprise a substantial proportion of these cases. In 1990, more than 208,000 youth between the ages of 12 and 17 years were reported to child protective service agencies as victims of abuse.[14] This represented 25% of all cases reported. Higher percentages of victims are reported when reports from agencies other than child protective services are included. In the NIS-1980, adolescents accounted for 47% of the reported cases and 42% of the substantiated cases, although they represented only 38% of the total population younger than 18 years of age. Estimates of the proportion of maltreatment occurring to adolescents in smaller, regional studies sampling a broader range of reporting agencies have generally been closer to those of NIS-1980. In Minnesota, 42% of cases of maltreatment involved adolescents.[21] A study of New York State cases reported that 31% of neglect reports, 42% of sexual abuse reports, and 19% of physical abuse reports involved adolescents.[22]

Comparisons of rates of adolescent maltreatment by age level are available in NIS-1988. Results of this survey indicated that adolescents were the age group with the highest overall incidence of maltreatment, showing a rate in 1986 of more than 23 cases per 1000 youth aged 12 to 17 years (NCCAN corrected rate).[15] Comparisons of data from NIS-1080 and NIS-1988 indicated that rates of abuse and neglect rose disproportionately among older children and adolescents. Successive age groups showed progressively larger increases in the incidence of abuse.

Comparisons of age differences in the type of maltreatment have been analyzed using data from NIS-1988 and two different definitions of maltreatment. When maltreatment was defined as including children who "experienced demonstrable harm as a result of maltreatment," the incidence of physical, sexual, and emotional abuse increased with age of the child.[15] When maltreatment was defined as including children who "were endangered by maltreatment, that is, placed at risk for harm, but not necessarily harmed yet," physical abuse occurred more frequently among older aged youths, and rates of sexual and emotional abuse did not change consistently with age. For adolescents, the greatest increases between 1980 and 1986 occurred in the areas of physical and sexual abuse.[15] Among adolescents, rates of sexual abuse tripled, and rates of physical abuse almost doubled. The increases were attributed to better recognition and measurement improvements rather than increased occurrence of abuse.[15] Reports from state child protective agencies have attributed recent increases in reported cases to better recognition and to increases in abuse due to worsening economic stress.[14]

Although there were no overall age differences in neglect, two subcategories of neglect showed large increases for adolescents between 1980 and 1986. Educational neglect, defined as parent-permitted long-term truancy, failure to enroll a child in school, and inattention to special educational needs, showed a rate of 10 per 1000 among youth aged 15 to 17 years.[15] Emotional neglect was also more common for adolescents and included inadequate nurturance/affection, long-term or extreme spouse abuse, permitted alcohol or other drug abuse or other maladaptive behavior, and refusal or delay in psychological care.[15]

By contrast with studies using officially reported cases, results from the NFVS showed no age differences in physical abuse, Data from this survey also showed that self-reported violence against children declined by 47% between 1976 and 1985.[11] Several levels of violence were measured through questionnaires administered by telephone or in person in which parents and youth were asked about the occurrence of specific violent acts. The 1975 survey included only households with two adults, while the 1985 survey included single-parent families as well. Very severe violence, defined as acts that were clearly abusive and included kicking, punching, biting, scalding, beating up, or threatening a victim with a knife or gun, showed no significant age differences. Despite the reported declines in violence, 2.1% of households reported using very severe violence with youths aged 15 to 17 years, a rate three times higher than that reported in NIS-1988[23]. In summary, the rates of maltreatment of adolescents are disturbingly high and the number of reported cases has increased since 1976. It is unclear if this represents an increase in actual incidence, better reporting of cases due to increased awareness, or changes in laws or state policies regarding the reporting of child abuse and neglect.

FACTORS CHARACTERIZING ADOLESCENT ABUSE

Perceptions of Abuse of Adolescents vs Younger Children

One of the most important factors distinguishing adolescent victims of abuse from younger victims is the perception by adults that older youth are less likely to be innocent victims of abuse. Stereotypes of victims as small and helpless, and of perpetrators as big and powerful, evoke sympathy and protective responses for younger child victims. The same is not true for adolescent victims whose cases tend to involve more complex dynamics and whose greater size, physical and cognitive abilities, and outside resources contribute to expectations that youth can protect themselves or avoid abusive situations.[24]

Societal beliefs that adolescence is a challenging period for parents may influence perceptions of adolescent maltreatment by both adults and youth. Parents of adolescents commonly report feelings of confusion, anger, and being unable to control their children's behavior.[25] Adolescent needs for greater independence and explorative behavior may add stress to family relationships and lead to frequent disagreements. One study found 90% of abuse incidents were preceded by the adolescent disobeying or arguing with the parent. While US definitions of acceptable discipline include more physical violence than other countries, negative societal attitudes toward adolescents may extend the boundaries of appropriate punishment and prevent youth from recognizing their abuse as exceeding normal discipline. In one study[7] of families with identified cases adolescent abuse, 40% of youth describe their behaviors as "responsible for or deserving of maltreatment. Similarly, in a survey of childhood disciplinary experiences in a large university population, 9% of the sample reported childhood experiences that met or exceeded a conservative definition of abuse. However, only 27% of the abused youth regarded themselves as having been abused.[27] This denial of abuse makes it unlikely these youth would seek help.

The adolescents' greater physical and cognitive abilities may also play a role in the increased likelihood youth will be held responsible for their maltreatment more often than younger children.[28] Their larger physical size may be seen as justifying a greater use of force and lesser likelihood of injury. Adolescents are more , likely to respond to parental abuse with mutual assault, which may contribute to the perception that they are more "deserving" of physical maltreatment.[29, 30] In some cases, the adolescent's assault against the parent succeeds in bringing a history of child abuse to the attention of authorities. Twenty-five percent of adolescent maltreatment cases reported in Connecticut were initiated through a police report of a youth assaulting a parent.[30] Perceptions of adolescents as responsible for their own abuse may thus contribute to the tendency of adults to overlook signs of abuse, to the decreased likelihood of reporting of adolescent abuse, and to the decreased likelihood that reports of abuse will be substantiated.

Gender Differences In Adolescent Maltreatment

Reports of gender differences in maltreatment as a function of type of abuse and age of victim have been somewhat inconsistent. For children younger than 12 years of age, some studies report that boys show higher rates of physical abuse than girls.[18,31,33] Other studies have reported no differences in physical abuse of girls and boys across all ages.[15] Adolescents show an opposite pattern with rates of physical abuse of adolescent girls either exceeding those for boys[14] or showing no differences.[23] Reasons proposed for possible higher rates of physical abuse of adolescent girls include greater parental concern over autonomy for girls, especially regarding dating and sexuality issues, and reluctance of parents to use physical force against adolescent boys due to their greater physical size and strength. An alternate explanation is that physical abuse against adolescent boys may be less likely to be reported due to greater societal acceptance of male involvement in violence or boys' concerns over appealing weak. Support for this explanation derives from research finding no gender differences in physical abuse of adolescents when parental self-reports rather than official reports are used.

In the area of sexual abuse, girls are reported as victims more often than boys at all ages.[15] Some researchers, however, have questioned whether this also reflects a greater reluctance to self-report by boys who have been sexually abused.[35,36] Most sexual abuse of boys involves perpetrators of the same sex. Especially during adolescence, male sexual abuse victims may be reluctant to report abuse due to fears that they will be seen as weak or homosexual. Abuse of boys is also more likely to involve unrelated persons and so would not be included in official reports. Substantiation-rates for abused male adolescents are higher than those for female adolescents, suggesting that cases , of both physical and sexual abuse in boys are not reported unless injuries are severe. [22]

Parental History of Abuse

Victims whose abuse occurs during adolescence are less likely to have parents who were victims of child abuse than are adolescents whose abuse, began during childhood.[7,37] Some researchers suggest this difference is strongest for youth whose abuse begins during adolescence, although this has not been systematically examined. The lower likelihood of a parental history of abuse suggests that adolescent abuse may reflect a lack of parental skills to cope with the changes of adolescence.

Family Poverty

The association between poverty and maltreatment appears to be weaker for maltreated adolescents than for younger victims. While Berdie et al[37] found an association between adolescent maltreatment and poverty, they also found that 42% of families showing adolescent-onset abuse earned in excess of $11,000 (1978 dollars) compared with only 11% of families with reported childhood-onset abuse. Other studies [7,15] have also reported that parents of adolescent victims tended to have a higher level of education and incomes closer to the overall population than parents of younger victims.

Age of Onset of Maltreatment

Although there has been no systematic study of how age of onset affects the course of adolescent abuse, three possible patterns of adolescent maltreatment have been identified: (1) abuse begins during childhood and continues into adolescence; (2) abuse begins with the onset of adolescence; and (3) abuse begins during adolescence, but parental behaviors may border on abusive during childhood.[38] An example of the third pattern would be a parent who spanked a younger child but used increased force as the child grew older so that during adolescence the child was hit with a fist.

It is difficult to isolate the effects of age of onset on the victim since most studies have not examined this variable or have failed to control for duration of the abuse. Some studies show that the e higher income and educational levels and decreased likelihood of parental history of abuse.mentioned earlier occur primarily for adolescent victims whose abuse begins during adolescence.[7,37]

It seems likely that childhood-onset maltreatment due to its long-term nature would have more serious and long lasting effects on the victim. In an in-depth study of 62 families, Garbarino et all found that families experiencing childhood-onset abuse (including cases of physical and sexual abuse) were more likely to show multiple problems, intergenerational abuse, and spousal abuse than were families whose abusive behavior began during adolescence.

Adolescent-onset abuse occurred less frequently

and was associated with periods of high stress in families.[7] Parents who begin maltreatment during adolescence have also been reported to be more amenable to treatment than those for whom maltreatment has been an established pattern since the youth's childhood.[7]

Early age of onset of sexual abuse has been found to be related to amnesia among adult survivors[39] and to late presentation for treatment .[40] However, a review of empirical studies of sexual abuse recently found no consistent relationship between symptomatology and age of onset of sexual abuse.[41]

Presence of Stepparents

Families with stepparents have been reported to be at higher risk for both physical and sexual abuse of adolescents and younger children.[7,26,37] However, several authors have argued that methodological flaws and the possibility of bias in official reports raise questions about these findings.[42] Official reports are analyzed using households as units of comparison and do not identify the relationship of the perpetrator to the child. Therefore, it is unclear if stepparents are more likely to perpetrate abuse than are genetic parents. In addition, agencies may be more likely to classify cases as abusive if a stepparent is present due to assumptions about differences between a child's relationship with a genetic and nongenetic caretaker.[42]

The 1985 NFVS found no differences between genetic parents and stepparents in their self-reported use of severe and very severe (qualifying as abusive) punishment.[42] Sexual abuse was not examined in this survey. Stepfathers have been overrepresented in official reports of sexual abuse. No differences have been reported in rates of abuse by stepparents of younger children vs adolescents, although adolescents are more likely to live in families containing stepparents.

These findings suggest that the presence of stepparents may not be a reliable risk indicator for physical abuse of adolescents. Presence of a stepfather may increase the risk of sexual abuse, but this is not specific to adolescents.

Family Functioning

Families at high risk for adolescent maltreatment have shown problems in the interpersonal relationships of family members. Risk factors have included poor adaptability, low cohesion, low levels of support, inconsistent use of discipline, and high levels of interparental conflict.[7] In one study, families involved in either physical or sexual abuse of adolescents were more likely to be *chaotic,* characterized by a lack of structure and organization, or *enmeshed*, characterized by excessive dependence on each other. Nonabusive families were more likely to be *flexible,* able to combine structure with responsiveness to situational conditions, or *connected*, able to have close relationships without finding them stifling. Abusive families were also characterized by high levels of conflict or, in some enmeshed families, extremely low levels of conflict.[7] A 2-year follow-up showed that some families dealt with the conflict by expelling the adolescent, while others seemed to suppress all manifestations of conflict.[7] Another dimension of family functioning examined in relation to adolescent abuse is parenting styles. Two parenting styles have been associated with physical abuse that began during adolescence: authoritarian parenting and overindulgent parenting.[39,43] Authoritarian families were characterized by harsh, rigid, engineering patterns of discipline and by parental denial of feelings toward each other and other family members. Incidents of abuse typically occurred when the adolescent challenged the parent by acting out. In attempts to regain control, the parents exerted inappropriate force.

Overindulgent families made few demands on their children and established few rules, but sought a high level of gratification from them. However, when their children reached adolescence and sought emotional closeness outside the home, overindulgent parents reacted with excessive force.[43]

While parenting style alone is not sufficient to predict if or when maltreatment will occur, it may influence the resolution of parent-adolescent conflicts and the way in which discipline is exercised. Use of physical force as a means of discipline may pose a high risk of abuse in the case of adolescents. The 1985 NFVS found that the use of physical punishment declines from early childhood into adolescence, although the incidence of violence at levels defined as abusive remains stable.[23] This suggests that physical punishment used against adolescents is more likely to be abusive than that used against younger children.

Developmental Issues

Several authors have suggested that developmental issues for both the youth and the parent contribute to parent-child conflicts, which may lead to adolescent abuse. When multiple members of a family undergo

transitions, as in parents entering midlife while their children enter adolescence, the family is subjected to great strain.[25] Simultaneous transitions for the adolescent and the parent may maximize the potential for conflict. For example, the adolescent may be experiencing increases in energy, sexual interests, and the need for independence as well as expanding opportunities in education or career areas. Parents' midlife transitions may include changes in sexual activities, lessening of physical energy, and increased awareness of career limitations. However, some evidence indicates that younger parents, not older parents, experience the most negative feelings regarding their child's onset of adolescence.[38] It may be that immaturity and unrealistic expectations about adolescent development are the critical factors that increase parental risk of maltreatment.

CONSEQUENCES OF MALTREATMENT

Although the incidence of death and serious physical injury as an immediate and direct result of maltreatment is lower for adolescents than for younger children, long-term consequences of maltreatment pose serious threats to their health. Research addressing the long-term consequences of maltreatment has been correlational, and firm conclusions about the precise relationship between abuse and risk behaviors are impossible. Few studies have separated the effects of maltreatment on later risk behaviors from the influence of living in a dysfunctional family that is not abusive. Despite these research limitations, however, the magnitude of health problems experienced by adolescent victims of maltreatment is daunting.

Health consequences associated with a history of sexual abuse for adolescents include premature or increased sexual activity, increased risk of unintended pregnancy, depression, increased attempts at suicide, chronic anxiety and feelings of vulnerability or powerlessness, confused sexual identity, alcohol and other drug abuse, and delinquency.[44-47] Similarly, adolescent victims of physical abuse have been reported to show generalized anxiety, depression, extreme adjustment and acting-out problems, academic difficulties, sleeping problems, increased drug use, self-destructive or reckless behaviors, suicidal ideation, and suicidal actions.[12, 48] Physical abuse of youth is also associated with violence by adolescents against both siblings[49] and parents.[29,50] Studies of abused youths also report an increased incidence of eating disorders and emotional problems, such as difficulty controlling anger or increased aggression.[8,44] Adolescents who are incarcerated, homeless or runaway, involved in drug abuse, or who have had a pregnancy during early adolescence are more likely to have a history of either physical or sexual abuse than are other youths.[22,51] In one study of runaway youths from eight states, 28% of the youths coming to the shelter reported that they had been abused prior to running away, and more than two thirds of these reported "being abused more than five times." Another study[52] reported that 38% of males and 73% of females ran away from home to avoid further sexual abuse.

Some adolescent responses to abuse, such as running away, increase the at risk of additional abuse or assault or lead to problems that are only indirectly related to abuse (e.g., prostitution).[53] A particular concern is the risk of acquiring human immunodeficiency virus infection. Clinical populations of abused males have been found to have higher rates of human immunodeficiency virus infection than comparable groups of nonabused males.[11]

SCREENING ADOLESCENTS FOR MALTREATMENT

Recommendations have been made recently that all adolescents should be asked annually about a history of emotional, physical, and sexual abuse.[54] Justification for this recommendation derives from the serious nature of risk behaviors associated with adolescent maltreatment and from strong national consensus that early identification of abuse is necessary to protect the physical and emotional well-being of the adolescent. As reviewed herein, adolescent maltreatment frequently goes undetected; self-disclosure is one of the major means by which adolescent abuse is discovered.[55]

When questions about abuse are included in the routine screening of adolescent patients, previously undiagnosed cases of abuse have been identified. Screening questions have been effective in identifying cases of sexual abuse of males.[55,56] One study of physical abuse among juvenile delinquents found that screening questions were most effective when they were presented in the following ways:

- using a variety of caretakers (e.g., asking about mother and father separately);
- using both direct (e.g., "Were you ever mistreated?") and indirect (e.g., "Who in your family has a bad temper?" or "How did your father act when drunk?") inquiries;
- using a nonthreatening context (e.g., focus on injury and how it was obtained or asking if youth had

ever been hit with an object without specifying who the abuser was); and

• using follow-up probes to gain additional information (e.g., "Did anyone else mistreat you?" or "What else happened?").[57]

In screening youth, health care providers should be aware that barriers to disclosure by youth can include incomplete recall of abusive events, perceptions by youth that abuse was deserved or appropriate punishment, and reluctance to attribute injurious intent to loved ones. Also, youth are often not straightforward or clear in their disclosure of abuse. The process of disclosure frequently includes an initial denial followed by an admission of abuse that is tentative, vague, or incomplete but becomes more detailed and clear over time.[55] Adolescents also may recant an initial disclosure of abuse, although they often reaffirm their allegation over time.[55]

REFERRALS FOR SERVICES FOR MALTREATED ADOLESCENTS

Health care providers should also be aware that the sequence of identification of maltreatment and referrals for services may differ for adolescents and younger children. Maltreated adolescents are more likely than younger children to initially come to the attention of the juvenile justice system, the mental health system, or alternative youth services network rather than child protective services.[31, 58] The point of entry into the service system often determines the label given to their behavior, how they are treated, and what services are made available to the youths.[22] For example, adolescents who escape family violence by running away may be less likely to receive medical services than those who are identified as abused at a hospital emergency department or at a protective service, agency.[44] Adolescents who react to maltreatment by engaging in violent or delinquent activities may be identified as juvenile offenders but not victims of abuse and consequently may not receive needed, medical or mental health treatment.

Adolescents also frequently experience problems in the child welfare systems.[34,37,59] Once identified as victims of maltreatment by other agencies, adolescents are the least likely group to be referred to child protective services. Reasons for failing to report adolescent abuse include a desire to provide services directly, distrust of child protective service agencies, unwillingness of youths to agree to file a report ind concern regarding confidentiality of the youth-provider communications, and beliefs that the case will not be accepted or the appropriate services provided.[58] Adolescents reported to child protective services often do not receive needed services since most available services address the needs of younger children. Adolescents require a broader range of services than younger children, including crisis counseling, drug counseling and education, sex education and contraceptive services, legal assistance, educational services, employment services, and short-term shelter. Adolescent receipt of services from child protective services has risen from 33% receiving services in 1976 to 55% receiving some services in 1982; however, they are still less likely to receive services than younger children."

Increases in the number of cases referred to child protective services cited herein pose an extremely difficult problem since a majority of states have received little additional funding for services.[20] The overload of the child protective system has recently led to efforts to set criteria for the reporting of abuse based on the severity of cases.[60] Prioritizing of cases based on severity of injuries may create a bias for continuing the focus on younger children and is likely to result in a continuing lack of services for adolescents.[10]

The child welfare system has recently emphasized programs to preserve families and reunite children with their biological parents. An advantage of some family preservation programs is that they view adolescents as an integral part of their family system and seek to assess and treat families as units.[6] A broad range of services, including parent education and skills training, family therapy, and psychological support and counseling, is provided to families, and specific and limited goals are set. Some programs have shown a high degree of success in preserving families.[6]

For some adolescent, victims with a long history of abuse, however, family problems may be intractable, and parents may not want the child to return home or may be unwilling to engage in treatment programs. Therefore, adolescents frequently need long-term placements or help in making a transition to independent living arrangements. However, adolescents also have more problems with foster care placements. One study[61] found that older adolescents averaged four different placements and one runaway episode while in foster cars. This is troubling since the more placements youths have, the more likely they are to have difficulties later in life.[6] Since recent family preservation policy mandates imply that only the severest cases will be referred to foster care, foster care will need to become more treatment oriented.

Adolescents are sometimes referred to the alternative youth system that includes shelters for homeless and runaway youths and independent-living programs. However, these programs are often unable to provide all of the comprehensive health services needed by youth, which may include mental health services, nutrition services, and treatment for sexually transmitted diseases, substance abuse, sexual assault, and physical ailments resulting from lack of shelter and sleeping quarters.[51] While many shelters contract for these services or receive donated services from health professionals, many health needs cannot be met due to financial or legal barriers.

The broad range of services needed by maltreated youths makes it imperative to coordinate services among child protective services, the alternative youth system, the health care system, and the juvenile justice system. Physicians' roles may include provision of health care services for youths in shelters and juvenile justice facilities as well as advocacy for funding of these services and for specialized treatment of adolescents within the child protective services system based on developmental needs.

SUMMARY AND RECOMMENDATIONS

Understanding of the problems of family violence and child abuse and neglect is enhanced by a consideration of issues unique to adolescent maltreatment and adolescent involvement in family violence. The current report has presented research indicating that maltreatment of adolescents is common, results in significant risks to health, and often involves identification and referral issues that differ from those of younger children. Therefore, the Council on Scientific Affairs recommends that the following statements be adopted and that the remainder of this report be filed:

1. That, the AMA use its communications mechanisms to do the following:

a. Encourage physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and other drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment:,

b. Urge physicians to consider issues unique to adolescents when screening youths for abuse or neglect.

2. That the AMA encourage state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent-living facilities, and treatment programs.

3. That the AMA investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development.

4. That the AMA alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment.

5. That the AMA urge youth correctional facilities to screen incarcerated youth for a current or prior history of abuse and neglect and to refer maltreated youth to appropriate medical or mental health treatment programs.

6. That the AMA encourage the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

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Television Viewing and Violence in Children: Pediatrician as Agent for Change

Robert Sege, MD, PhD
William Dietz, MD, PhD

SUMMARY RECCOMENDATIONS FOR PEDIATRICIANS

Three decades of research suggest a causal link between exposure of children to violent images on television and subsequent violent behavior. The epidemic of violence in American society mandates a critical reappraisal of the televised images that children see. To slow the cycle of violence, pediatricians can: (1) Help shape parental attitudes toward children's viewing habits; (2) lobby for school systems to adopt curricula that include critical viewing skills; and (3) work with Congress, Federal regulators, television producers, and broadcasters to reduce the exposure of children to televised violence. *Pediatrics* 1994;94:600-607; *violence, clinical practice, television, advocacy.*

The time is long past due for a major, organized cry of protest from the medical profession in response to what... I consider a national scandal.

-From Michael Rothenberg, "Effect of Television Violence on Children and Youth." JAMA. 1975[1]

Television is a central feature of contemporary American life. American children spend more time watching television than they do in school .[2] Thus, television has tremendous potential as an educational medium. Shows like *Sesame Street,* for example, teach social skills, self-respect, and reading readiness. Television also has a variety of adverse effects, however, as indicated by recent statements from the American Academy of Pediatrics (AAP).[3-9] One of the most important of these effects results from the exposure of children to televised violence.

In the make-believe world of television, violence is a commonplace and accepted part of life. Violent acts, defined as acts intended to injure or harm others, appear approximately 8 to 12 times an hour on prime time television and about 20 times an hour on children's programming. Cartoons, a staple of many children's morning and weekend routines, are especially laden with violence.

The cumulative effect of these numbers is staggering. Children spend approximately 25 hours per week watching television. If we assume that two thirds of this time is spent watching prime time television and

approximately 150,000 Medicare admissions to acute care facilities in Mississippi during 1993. All CVD-related admissions by case, total charge, and average charge are described in Table 1.

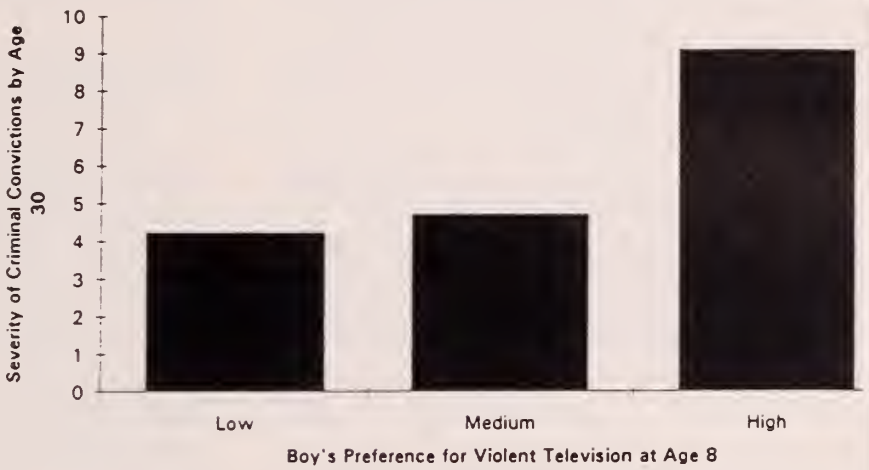


Fig 1. The relationship between a boy's preference for violent television shows at age 8 and the seriousness of his criminal convictions by age 30. Adapted from Huesmann.[14]

one third watching children's cartoons, we find that children are exposed to a conservative estimate of over 12 ,000 violent acts per year.[10] In this article, we will consider the evidence that relates televised violence to the behavior of children and will examine how parents and pediatricians can mitigate the effects of such violence.

Childhood Learning and Violence on Television

The violence seen on children's television is often of a special, stylized type. Violence on television is frequent, inconsequential, effective, and rewarded. It is practiced as often by the heroes as by the villains. Violence ends confrontations quickly and effectively, without a need for patience, negotiation, and compromise. Furthermore, television rarely shows the lingering psychological and physical effects of violence. In short, televised violence effectively solves problems and resolves conflicts, receives social affirmation, and rarely causes pain or suffering.

The concept of violence without pain, a unique contribution of American media, pervades our thinking. In *Deadly Consequences,"* Deborah Prothrow-Stith recounts the story of a young man she saw in the Emergency Department at Boston City Hospital. He was surprised and angry to discover that being shot really hurt; it never seemed to hurt on television.

Because children learn from what they see, it should surprise no one that the violence on television clearly provokes violent or aggressive behavior in children. Several mechanisms have been identified. First, the absence of consequences of the violence that they see and the rapidity with which difficulties are resolved by the use of violence increase the likelihood that violence will be among the first strategies that a child selects, rather than the last. Second, the rewards that the heroes receive for their violent behavior legitimize and tacitly endorse violence as a means of solving problems. Finally, the frequency with which children view violence and the lack of long-term consequences for the victims of violence desensitize children. Thus they are led to passively accept violence as a fact of life, making them less likely to intervene when violence occurs.

The effect of television on the world view of adults, who are presumably less impressionable than children, illustrates television's power. George Gerbner of the Annenberg School of Communication in Pennsylvania has studied adults who watch large amounts of television.[12] By and large, these viewers have a "mean world syndrome." Their views of the real world are filled with feelings of danger, mistrust, intolerance, gloom, and hopelessness. They see their own world on television's terms, including its preoccupation with criminals, police, and violence. As a result, they are more likely to think that people will attack or injure them and less likely to think that peaceful mediation will resolve conflicts successfully.

In recent congressional testimony,[13] Ronald Slaby, a developmental psychologist and author of an American Psychological Association study of violence in America," reported that television violence produces four types of harmful effects on viewers: (1) an

"aggressor effect," defined as an increased tendency for people who watch large amounts of television to behave violently towards others; (2) an increased fearfulness of becoming a victim of violence; (3) a "bystander" effect, characterized by increased callousness and desensitization towards actual violence; and (4) a cycle whereby aggressive children who watch a lot of violence on television identify with violent characters, act like those characters, and seek out more and more violent programming.

It would be simplistic to blame *all* of the violence in society on television. The easy availability of guns, the prevalence of severe poverty in parts of the population, the prevalence of violence in the home, and numerous other factors all contribute to the epidemic-. The real question, then, concerns how much television violence contributes to the growing problem of violence in America.

THE LINKAGE BETWEEN CHILDHOOD TELEVISION VIEWING AND SUBSEQUENT VIOLENT BEHAVIOR

Decades of research have firmly established the link between viewing television depictions of violence and the subsequent development of violent behavior. Currently, investigators believe that this effect is mediated through a social learning model: ie, children learn through watching, imitating, and assimilating information about the functioning of adult society.[15] Children, particularly young children, are not cognitively equipped to distinguish the world as portrayed on television from the real world in which they live.

The adult world fascinates children, who learn by actively imitating adults around them. In a now classic series of experiments conducted in 1963, Bandurall demonstrated that preschoolers can learn novel aggressive behaviors by watching television. In a set of televised films shown to three groups of children, a male actor walked up to an adult-sized clown doll and ordered it to move away. When the doll didn't move, the actor attacked the doll, first with his fists, then with a mallet, and then with rubber balls. Children in one group saw the actor rewarded with candy. The film shown to the second group ended without reward or punishment to the aggressor. In the film shown to the third group, the actor was verbally reprimanded. After viewing the film, those children who had seen the actor rewarded or treated neutrally acted aggressively compared to those children who had not seen the film or who had seen the actor punished.

Subsequently, three lines of investigation have examined the relationship between television viewing and violence in more natural settings: naturalistic field studies, longitudinal studies, and population based studies.

Naturalistic Field Studies

In general, the field study format for many studies of the effects of television violence have been similar. An experimental group of children in an institutional setting, such as a prep school, is exposed to violent mainstream media productions while a similar control group is exposed to nonviolent programs. Trained observers monitor the behavior of the children after exposure, grading their aggressive or violent behavior. Meta-analysis of a large number of these studies clearly demonstrated that exposure to media violence significantly increased subsequent aggressive behavior in this setting.[17,11] These studies have not examined whether these exposures have long-lasting effects, whether repeated exposures cause a cumulative effect, or whether a dose-response relationship exists between exposure and subsequent violent actions.

Longitudinal Studies

Case control and cohort studies of violent criminal offenders have been conducted to examine the temporal relationship of television viewing to violent or aggressive behavior and the strength and duration of this relationship. One of the best of these studies was a 22-year prospective study of 8-year-old children reported by Huesmann in 1986 .[19,20] Criminal acts at age 30 correlated with both the total amount of television watched at age 8 and a preference, among boys, for violent television (Fig 1). These results persisted when controls for parental behavior and socioeconomic-tic status were introduced.

Although cohort studies provide detailed information about their subjects, the relatively small number of subjects and the incompleteness of follow-up may not allow control for confounding variables that were not measured. Furthermore, because most cohort studies do not include a representative population, results rarely can be generalized.

Population-Based Studies

In an attempt to expand the investigation of the relationship between televised violence and behavior to several populations, Centerwall[21, 22] examined homicide rate trends in three countries before and after the introduction of television. His analysis included Canada, the United States, and South Africa.

For comparative purposes, only the white populations in the US and in South Africa were included. Because Canada is 97% white, national statistics for Canada were used. These three countries were selected because they were technologically developed, they had other media available, and they were English-speaking societies exposed to programming largely of American and British origin. Television was introduced at different times in each country, allowing the two other countries to act as controls.

As shown in Fig 2, 10 to 15 years after the introduction of television in each country, homicide rates increased more than twofold. Subgroup analysis in the US showed a similar trend. Urban homicide rates increased before rural rates, perhaps because television was introduced into larger markets first. Because television was originally a luxury inaccessible to most minority Americans, one would expect that homicide rates would have increased first among the more affluent white population, and this trend was observed, as predicted. Similarly, homicide rates increased earlier in those geographical regions of the country in which television was first introduced compared to those regions in which television was introduced later.

Centerwall's studies do not include a measure of the specific content of television violence, but all three countries used American television in varying degrees to fill their programming needs. Despite Centerwall's observations, other unmeasured factors in each country may have been responsible for the increase in homicides. In the US, military involvement in Vietnam, and in South Africa, the battle over the apartheid system occurred contemporaneously with the time period under study. Finally, the study coincided with massive shifts in the structure of the family and major shifts in cultural norms. Therefore, Centerwall's observations must be treated with caution.

DOES WORK ON THIS PROBLEM MEET CAUSALITY CRITERIA?

In 1964, the Surgeon General's Report on Smoking and Health" established five criteria by which epidemiologic causality may be established: the temporal relationship between variables, the consistency of the association on replication, the strength of the association, the specificity of the association, and a coherent explanation that would account for the findings. The association between childhood viewing of television and subsequent development of violent behaviors meets all of these criteria.

Time Sequence of Variables

The cohort studies described above clearly establish that people who watch more television violence as children are more likely to be criminally violent as adults. In Centerwall's studies, homicide rates increased 10 to 15 years after the introduction of television. Thus, the introduction of television both predates the increases in homicide rates and suggests that television violence has its primary effect on children.

Consistency of Association

Virtually every study undertaken to examine the relationship between television and violence has demonstrated a positive association. The theory that viewing dramatic violence would have a cathartic effect on violence-prone individuals has been discredited. In this review, three disparate types of studies have been examined, each with specific strengths and shortcomings. All three types of studies have established such an association.

Strength and Specificity of Association

In most studies, the association of television with violent and oppressive behavior was significant. Furthermore, the associations persisted when controlled for a variety of other variables known to influence violent or aggressive behavior.

Coherence

The influence of television stems from the innate ability of children to learn and to imitate behaviors. Social learning begins at a very early age. As outlined above, the frequency with which violence is portrayed, and the tacit endorsement that accompanies televised violence, makes it an attractive behavior that children imitate.

Investigators have traced the effects of viewing television violence from the individual child to society as a whole. In laboratory settings, viewing

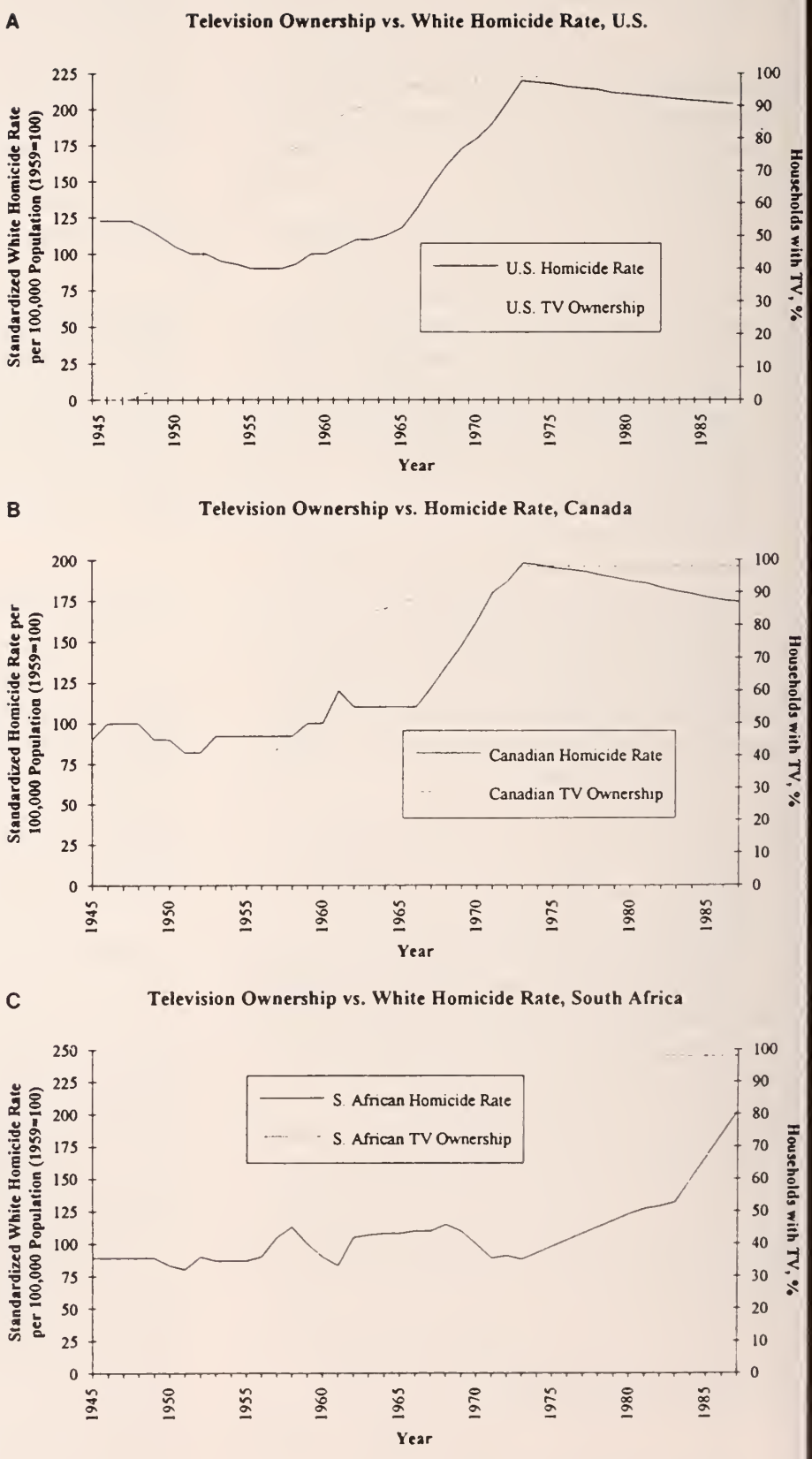


Fig 2. The relationship between television ownership and homicide rates within the white populations of the US and South Africa and in the Canadian population, 1946 through 1987. Adapted from Centerwall.[20,21]

of individual preschoolers. Similar effects are seen in field studies of small groups of school age children. Cohort studies demonstrate long-term effects. Finally, the correlation of the availability of television and subsequent increases in homicide rates suggest that these results are generalizable.

In the case control and cohort studies, there appeared to be a dose-response relationship. Boys who reported viewing preferences for violent programming as children behaved more violently as adults. These results conform to ideas and theories about how children learn and fit with a social-learning model for the effects of television on subsequent behavior.

In summary, research evidence to date leaves little doubt that childhood exposure to depictions of violence on television results in an increased risk of subsequent violent behavior.

HOW PEDIATRICIANS CAN RESPOND TO THIS PROBLEM

Despite the evidence that excess television watching among American children has negative effects, television performs an important function in many American homes: it provides important in-home diversion for children. Any discussion of the possible role of pediatricians in reducing the effect of television on American children must acknowledge this reality first.

Given such a caveat, pediatricians can address the fundamental problem of televised violence and associated violent behavior at three levels: in the family, in the school, and through legislative and regulatory approaches.

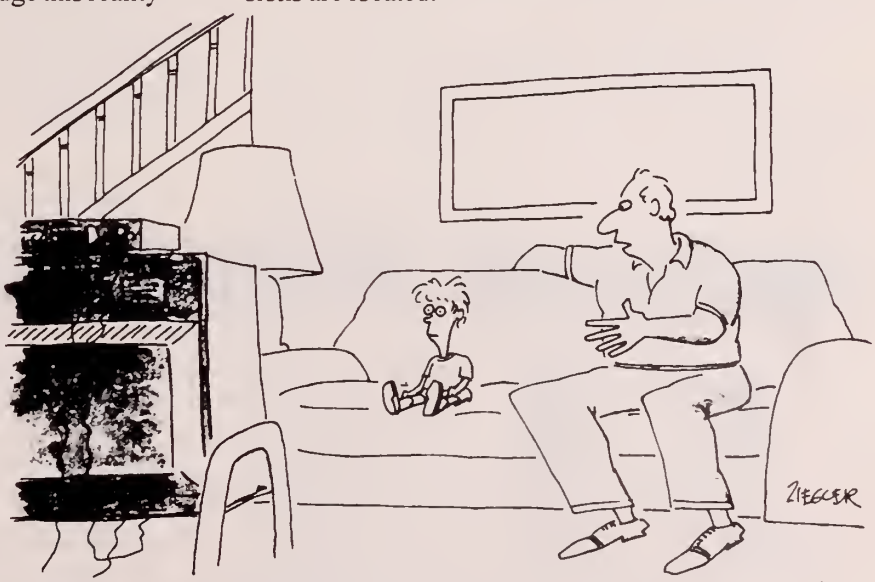
The Family and the Pediatrician

Pediatricians are quite comfortable in asking questions about parenting practices and in providing anticipatory guidance around behavioral issues. A majority of the time spent in most health supervision visits focuses on these issues. Because parents turn to pediatricians as authorities on such issues as sleep, school function, and discipline, pediatricians are ideally situated to provide advice regarding television viewing practices.

The time pressure of busy clinical practice dictates that interventions be specific and efficient. Therefore, advice offered in the practice setting must be provided as simple take-home messages designed to maximize impact.

Certain approaches can help in the office setting. First, pediatricians can obtain a "television viewing history" from patients/parents in a relatively straightforward way:

- Ask the parent where the household televisions are located.



"You see? Once more, Wile E. Coyote is restored swiftly and miraculously to health. His potential trauma has been trivialized, and we are yet again amused."

Fig 3. Drawing by Ziegler, 1993. *The New Yorker* Magazine, Inc. All rights reserved.[9]

· Ask how much television the child watches after school, after dinner, and on weekends.

· Ask the child to name a few of his or her favorite shows.

Parents should be told, briefly, why the pediatrician is concerned about television viewing. The pediatrician should mention not only exposure to violence, but also such issues as obesity, cognitive development, and stereotypes.[24-29]

Parents should be advised to control television in the home: (1) there should be no television sets in children's rooms, where parents cannot see what shows their children are watching; (2) parents should monitor their children's viewing choices; (3) parents should limit the total amount of television viewed by their children (the AAP currently recommends no more than 2 hours of television per day per child); and (4) if necessary, parents should use devices to block unauthorized television viewing. Available options range from inexpensive locks designed to fit a television's electrical plug to more sophisticated electronic units.

Beyond limiting access to television, parents should be encouraged to watch television with their children to help them learn the difference between television and their own lives and values (Fig 3) .[31] Even young children can analyze the content of televised programs. Parents can ask simple questions, such as

* Is this real or pretend?
* Is this how we do things at home?
* What do you think would happen if *you* did that?

Because parental reaction may mitigate the effects of televised violence [32] parents should be encouraged to share their own reactions to what they see on television, thereby teaching children that their own family does not approve of violence. These messages can be incorporated into anticipatory guidance. Brochures are available from the AAP and from the authors (Fig 4).

Use of medical settings as an example may help to establish a norm for parents to emulate. Currently, in many pediatric emergency departments, children receive care for intentional injuries in one room while parents and children watch violent programs in adjoining waiting rooms. Television sets in doctor's offices, waiting rooms, pediatric emergency departments, and pediatric wards should not be tuned to commercial television with violent programuning. A sign like this one would send a useful message: "Because of the violent content of commercial programming, this waiting room's television is tuned to a public television channel."

The Pediatrician as Advocate in the Wider Community

Schools, hospitals, and parent groups often utilize pediatricians as consultants. In each of these situations, pediatricians can and should emphasize the importance of diminishing the exposure of children to televised violence. For example, when a pediatrician advises school systems on health education issues, the

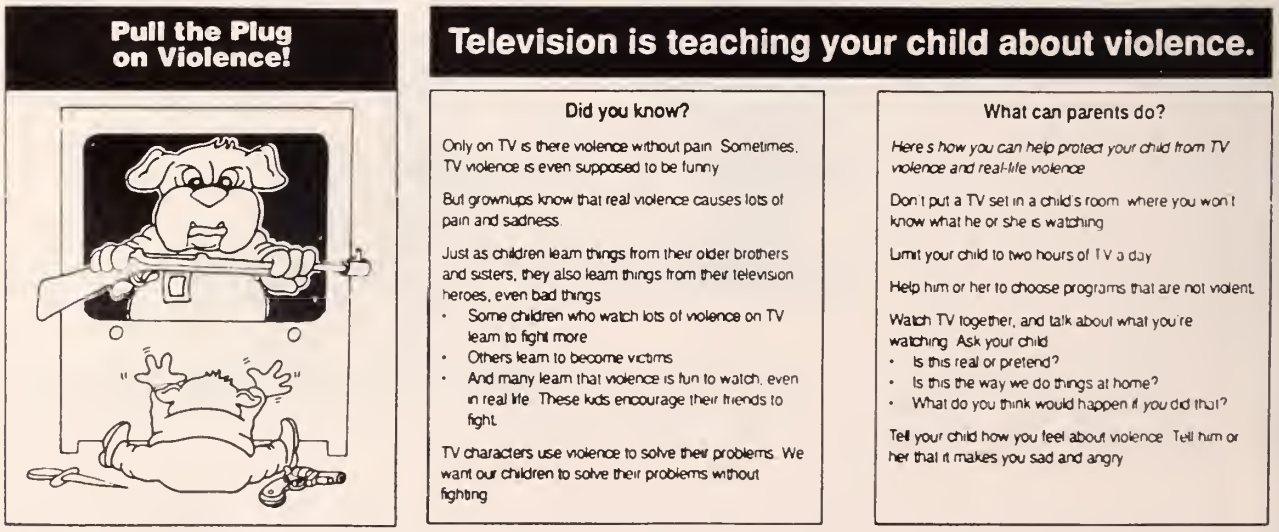


Fig 4. Brochure developed and used by the Harvard Community Health Plan Foundation to educate parents about how to mitigate the effects of television violence.

physician should advocate for the inclusion of media literacy programs to help teach children how to view television (vide infra). Community based "television turn-offs" or other community-wide educational programs may also present situations in which pediatricians can play an effective role.

Many school systems across the country have adopted curricula designed to promote critical viewing skills. These curricula teach children how television programs are made and how to read the intent of the director and the producer from the way a television program is constructed. Such programs have effectively taught school-age children to understand the commercial nature of television, but few curricula include segments designed to reduce the effects of viewing televised violence.

One exception was a demonstration project aimed at aggressive second and fourth graders who were selected for their high exposure to television violence .[33] A simple intervention involving three training sessions over a 6- to 8-week period showed no discernible effect on increasing aggression after 3 to 4 months. A second intervention conducted the following school year enabled the same children to make a film to show how other children had been harmed by television violence, while a control group made a film on why everyone should have a hobby. After the second intervention, increases in aggression in the experimental group were smaller than in the control group, but the intense nature of the intervention and the long time period required for it raise concerns about how applicable this approach would be in other settings.

Beyond such logistical concerns, use of such curricula to reduce the effects of televised violence presents several additional problems. First, children begin viewing television long before school age. Current curricula designed to teach critical viewing skills are generally aimed at high school students, with a few more recent programs aimed at middle school.[34] In younger children, the cognitive ability to separate fantasy from reality has not yet been developed. Thus, most preschoolers have active fantasy play, they often have imaginary friends, and, in general, they are actively involved in learning the difference between fantasy and reality. These children are unable to dissect the messages of television in a sophisticated fashion. Because attitudes and behaviors about violence are developed at a young age and appear to have a long-lasting effect," however, the development of curricula aimed at younger children may have a greater impact. Long-term studies of the effectiveness of critical viewing curricula in a variety of age groups and settings are essential.

It is not clear whether long-term relationships between the commercial broadcasting industry and groups like the AAP can be developed. The goals of the two groups are often antithetical. For example, the AAP would reduce the children-aimed advertising on which the networks depend. If an issue within the broadcast industry depends on whether concerns for children will outweigh commercial interests, children will probably lose. The most successful strategy to promote changes in programming will be one demonstrating that reduced televised violence aimed at children is good business. Implementation of this strategy is likely to require activity in the public sector to create a demand and in the broadcast industry to create a product. Whether the AAP can position itself to do both represents the current challenge.

Regulatory and Legislative Approaches

If pediatricians and their groups are to influence this problem using. regulatory and legislative approaches, they will need to be aware of the prospects for self-regulation by the industry and of the role that government regulation is likely to play.

Prior to a 1984 antitrust ruling, the National Association of Broadcasters had standards for the violence shown on television. In 1990, Congress exempted the networks from certain antitrust provisions, allowing the networks to discuss the issue once again. The major broadcast networks subsequently produced written standards similar to the old National Association of Broadcasters code.[16]

The new standards proscribed gratuitous or excessive depictions of violence; depictions of violence as glamorous or as an acceptable solution to human conflict; depictions of violence designed to shock or to stimulate the audience; and scenes showing excessive gore, pain, or physical suffering. The standards also urged that televised violence be portrayed with its consequences and that portrayals of callousness or indifference to suffering experienced by the victims of violence be avoided. Subsequently, the industry also promulgated a "Parental Advisory Plan" [37] which called on networks to voluntarily advise viewers about violent programs.

Unfortunately, it appears unlikely that such measures will have a significant impact on the effects of televised violence on children, as discussed else-

where in this supplement. In the fall of 1993, only one regularly scheduled program carried the parental warning. Moreover, broadcasters continue to insist that the marketplace determines to a great extent what is shown on television.[38-40]

For these reasons, simple measures that do not impinge on First Amendment rights of broadcasters are crucial. The movie industry has regulated itself, at least in terms of sexual explicitness, since the 1930s. At that time, the industry faced a wide variety of pressures from local and state censorship boards, federal authorities, and large organized groups such as the Legion of Decency, a Roman Catholic reviewing and rating body with the power to launch substantial boycotts.[41] Sixty years later, self-censorship remains in place because it enables moviemakers to address regulatory pressures while retaining control over every aspect of their business.[41] A similar set of pressures from parents, pediatricians, public health professionals, educators, the Federal Communications Commission, and Congress might achieve equivalent success with regard to meaningful self-regulation of the television industry.

Regardless of the mechanism, a long-term goal remains the development and promotion by broadcasters of alternative strategies to resolve confrontations depicted on television as well as alterations in the frequency and characterization of violence. In this regard, the Japanese experience is instructive. In Japan, televised violence occurs with a frequency comparable to that in the US,[43] but violence on Japanese television tends to be portrayed more realistically, and the consequences are emphasized. The villains use violence more than the heroes, and the heroes suffer the consequences. Such portrayals are much more likely to provide children with an aversion to violence and to reduce the likelihood that violence will be the first strategy they adopt to resolve conflict.

Government Regulation

If the government fails to regulate itself, the government may intervene. As Centerwall recently noted, "If someone were to call on the tobacco industry to cut back tobacco production as a matter of social conscience ... we would regard that person as being at least simple-minded, if not frankly deranged. Oddly enough, people have persistently assumed that the television industry operates by a higher standard of morality "[44]

In response to public opinion and the seeming intransigence of broadcasters, various legislators have introduced a number of bills designed to either curb televised violence or empower parents to exclude violent programs from their television sets. The Television Violence Reduction Through Parental Empowerment Act of 1993 (HR 2888) would require that all new television sets include built-in circuitry to allow viewers to block the display of channels, programs, and time slots; and that such mechanisms enable viewers to block display of all programs with a common rating, such as a violence rating. This type of device is currently available as an option on more advanced television sets; advocates estimate that mass production of these chips would reduce the additional cost to approximately $1 per set.

This approach, however, has several potential problems. First, implementation would depend on the willingness of broadcasters to voluntarily identify violent programs. Second, a negative rating may attract some viewers, including children and teens, whom the device is designed to protect. Third, this system will not be likely to rank cartoons as violent, even though violence shown in cartoons is the most frequent and the least consequential violence on television, and it is often portrayed as humorous.

Other proposed legislation expands the Federal Communications Commission's licensing authority. The Children's Television Act of 1990 called for an increase in quality children's programming. Pediatricians may be able to use the provisions of this act to work with their local broadcast stations, as discussed extensively in the article by Charren, Gelber, and Arnold.[30]

CONCLUSIONS

Violence in the US is epidemic. Fortunately, our knowledge of some of the factors underlying the epidemic is also increasing. Simple changes in the routine practice of pediatrics, as well as in the legislative agendas of our organizations, may have a major impact on the violence to which our children are now exposed.

Pervasive changes in public attitudes regarding cigarette smoking and diet occurred in response to consistent messages from the medical and public health communities. Research evidence that links televised violence to violent behavior is now firmly established. The time has now come for the pediatric community to communicate these findings to our patients and their families.

ACKNOWLEDGMENTS

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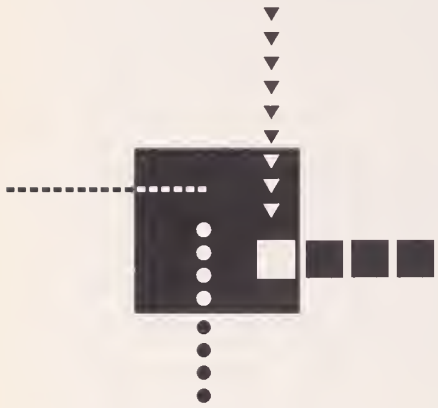
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Organized Medical Staff Section

Twenty Sixth Assembly Meeting
November 30–December 4, 1995
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Diagnostic & Treatment Guidelines on Domestic Violence

Breaking The Silence

The effect was chilling... Nicole Brown Simpson's voice of hopeless resignation punctuated by O. J.'s background rantings. It was indeed the tape epitomizing domestic violence heard 'round the world.

Even more chilling are those cases of domestic violence in our own practices that go undetected... Mrs. Reticent whose husband insists on remaining in the exam room and answers all questions directed to her... Mrs. Noshow who repeatedly misses appointments... Ms. Shiner who attributes her black eye to a runaway wand at the car wash...

Domestic violence is generally defined as physical, verbal, and/or emotional abuse of a woman by an intimate partner, typically a current or ex-husband or boyfriend. While approximately two million women are severely assaulted by male partners annually in the United States, more than 27,000 Mississippi women called crisis lines between June l, 1993, and June 30, 1994, and more than l,000 women and 1,500 children were served in domestic abuse shelters in our state.

Family violence occurs among persons within family or other intimate relationships and includes child abuse and elder abuse as well as domestic violence.

Addressing a problem of this magnitude requires the expertise, time, and dedication of a wide variety of professionals. Until now, interventions have focused on shelters, police response, legal action, and legislation. But now we as physicians must become more involved in recognizing domestic abuse as a health problem and in assuming greater roles in addressing this subject among our patients.

The AMA's Council on Scientific Affairs has recently published health care goals for identifying and treating suspected domestic abuse victims. With a phone call to the AMA National Medical Resource Center (312/464-5066) along with a three dollar donation, you will receive invaluable materials on the diagnosis and treatment of domestic abuse as well as a membership in the National Coalition of Physicians Against Family Violence. Placards and posters for exam room display will identify you as a physician committed to the detection and treatment of domestic violence.

Family violence doesn't just happen to other people; it happens to our patients and in our own families. And it's a problem that doesn't cure itself. When we as physicians allow such victims to break their silence, we then allow the cure to begin.

D. Stanley Hartness, Jr., MD
President
Mississippi State Medical Association

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Introduction

Physical and sexual violence against women is a public health problem that has reached epidemic proportions. An estimated 8-12 million women in the United States are at risk of being abused by their current or former intimate partners. This violence causes serious physical, psychological, and social sequelae for these women and their families.

Domestic violence, also known as partner-abuse, spouse-abuse, or battering, is one facet of the larger problem of family violence occurs among persons within family or other intimate relationships, and includes child abuse and elder abuse as well as domestic violence. Family violence usually results from the abuse of power or the domination and victimization of a physically less powerful person by a physically more powerful person.

Until the mid-1970's, assaults against wives were considered misdemeanors in most states, even when an identical assault against a stranger would have been considered a felony. The current consensus among state and federal policy makers is:

- Domestic violence is a crime.
- Safety for victims of domestic violence and their children must be a priority.
- Changes in traditional services, including medical are needed to meet the needs of abused women.

Most states have improved the legal remedies available to battered women, and a number of state health departments have developed protocols for health care providers. Since January 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has required that all accredited hospitals implement policies and procedures in their emergency departments and ambulatory care facilities for identifying, treating, and referring victims of abuse. The standards require educational programs for hospital staff in domestic violence, as well as elder abuse, child abuse, and sexual assault.

Because a physician may be the first nonfamily member to whom an abused woman turns for help, he or she has a unique opportunity and responsibility to intervene. Battered women often present with repeated injuries, medical complaints, and mental health problems, all of which result from living in an abusive relationship. Physicians in all practice settings routinely see the consequences of violence and abuse, but often fail to acknowledge their violent etiologies. By recognizing and treating the effects of domestic violence, and by providing referrals for shelter, counseling and advocacy, physicians can help battered women regain control of their lives.

These guidelines are intended to:

- Familiarize you with the magnitude of the problem.
- Describe how to identify abuse and violence through routine screening and recognition of clinical presentations.
- Help you assess the impact of abuse and violence on your patients' health and well being.
- Provide examples of how to ask questions in ways that can elicit meaningful responses and help women to explore their options and take action.
- Provide information on appropriate resources for referral and address frequently encountered obstacles.
- Familiarize you with the legal aspects of medical care, including reporting requirements.

Facts About Domestic Violence

Domestic violence is characterized as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation. These behaviors are perpetrated by someone who is or was involved in an intimate relationship with the victim. Although some women are successful in escaping a violent relationship after the first assault, most abuse is recurrent and escalates in both frequency and severity. In addition, a woman's independence may be compromised by her partner's need to dominate her and control many aspects of her life: He may restrict her access to food, clothing, money, friends, transportation, health care, social services or employment.

Research has failed to demonstrate a psychological or cultural profile of battered women. However, certain groups of women appear to be at somewhat higher risk for abuse; women who are single, separated, or divorced (or are planning a separation or divorce); women between the ages of 17 and 28; women who abuse alcohol or other drugs - or whose partners do; women who are pregnant; or women whose partners are excessively jealous or possessive. Children raided in violent homes may be at increased risk for perpetrating or experiencing violence in adulthood, but not all abusive partners or abused women were exposed to family violence while growing up.

Domestic violence cuts across all racial, ethnic, religious, educational, and socioeconomic lines. However, physicians should be aware that a woman's family background, as well as her cultural and religious beliefs may influence her perceptions of abuse.

In addition, her socioeconomic status influences her access to medical care. Women of higher socioeconomic status are more likely to seek care in private practice settings, while low-income women are more likely to go to clinics and emergency departments.

Conservative studies indicate that two million women per year are assaulted by their partners, but experts believe that the true incidence of partner violence is probably closer to four million cases per year.

- Nearly one quarter of women in the United State - more than 12 million - will be abused by a current or former partner some time during their lives.
- 47% of husbands who beat their wives do so three or more times a year.
- According to FBI statistics, 30% of women who were murdered in 1990 were killed by husbands or boyfriends.
It is estimated that 52% of female murder victims were killed by a current or former partner.
- 14% of ever-married women report being raped by their current or former husbands, and rape is a significant or major form of abuse in 54% of violent marriages.

Most research has focused on woman who have been battered by male partners, and, in fact, women are more likely than men to be seriously injured by their partners. However, the terms spouse-abuse and partner-abuse reflect an awareness that men also can be abused in intimate relationships. The extent to which findings about battered women can be applied to men who are abused by women, or to the under recognized problem of violence within gay and lesbian relationships, is not known. In clinical practice, these issues also must be addressed in a sensitive and nonjudgmental manner.

Forms of Abuse

Domestic violence is an ongoing, debilitating experience of physical, psychological and/or sexual abuse in the home, associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. Whenever a woman is placed in physical danger or controlled by the threat or use of physical force, she has been abused. The risk for abuse is greatest when a woman is separated from supportive networks.

Physical abuse is usually recurrent and escalates in both frequency and severity.

It may include the following:

- Pushing, shoving, slapping, punching, kicking, choking.
- Assault with a weapon.
- Holding, tying down, or restraining her.
- Leaving her in a dangerous place.
- Refusing to help when she is sick or injured.

Emotional or psychological abuse may precede or accompany physical violence as a means of controlling through fear and degradation. It may include the following:

- Threats of harm.
- Physical and social isolation.
- Extreme jealousy and possessiveness.
- Deprivation.
- Intimidation.
- Degradation and humiliation.
- Calling her names and constantly criticizing, insulting and belittling her.
- False accusations, blaming her for everything.
- Ignoring, dismissing, or ridiculing her needs.
- Lying, breaking promises, destroying trust.
- Driving fast and recklessly to frighten and intimidate her.

Sexual abuse in violent relationships is often the most difficult aspect of abuse for women to discuss. It may include any form of forced sex or sexual degradation, such as:

- Trying to make her perform sexual acts against her will.
- Pursuing sexual activity when she is not fully conscious or is not asked or is afraid to say no.
- Hurting her physically during sex by assaulting her genitals, including use of objects or weapons intravaginally, orally, or anally.
- Coercing her to have sex without protection against pregnancy or sexually transmissible diseases.
- Criticizing her and calling her sexually degrading names.

Interviewing Process

Domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify routine screening of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. Because some women may not initially recognize themselves as "battered," the physician should routinely ask all women direct, specific questions about abuse. Such questions may be included in the social history, past medical history, review of systems, or history of present illness, as appropriate.

Although women may not bring up the subject of abuse on their own, many will discuss it when asked simple, direct questions in a nonjudgmental way and in a confidential setting. The patient should be interviewed alone, without her partner present. The physician should make an opening supportive statement, such as: "Because abuse and violence are so common in women's lives, I've begun to ask about it routinely," Even if the patient does not respond at the time, the fact that a provider is concerned and believes that bettering is a possibility will make an impression. The physician's concern about abuse validates her feelings and reinforces her capacity to seek help when she feels ready and able to do so.

Routine questions about violence not only identify women who are currently being abused but also serve to assess the safety of women who have been battered in the past and to heighten the awareness of those who have not been in abusive relationships. Routine assessment is particularly important for women who have left a violent relationship; leaving an abusive partner or finalizing a divorce may increase her risk for abuse. The physician should provide appropriate follow-up during legal proceedings, and assess the woman's need for emergency shelter or other resources.

A medical encounter may provide the only opportunity to stop the cycle of violence before more serious injuries occur, and intervention begins by gathering information. Providing the woman with a different kind of experience, one in which she is respected and taken seriously; one that lets her know she is respected and taken seriously; one that lets her know she doesn't deserve to be abused; one that offers the possibility of support and safety, and one that encourages her own choices and decision making is, in itself, therapeutic and an important step. Questions about domestic violence should be asked in the physician's own words and in a nonjudgmental way. Here are some examples of recommended questions:

- Are in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
- Are you (have you ever been) in a relationship in which you felt you were treated badly? In what ways?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has your partner ever forced you to have sex when you didn't want to? Does he ever force you to engage in sex that makes you feel uncomfortable?
- We all fight at home. What happens when you and your partner fight or disagree?
- Do you ever feel afraid of your partner?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- You mentioned that your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? is he ever verbally or physically abusive?
- Do you have guns in your home? Has your partner ever threatened to use them when he was angry?

Diagnosis and Clinical Findings

Injury: Episodes of physical assault characterize abusive relationships. Physicians should especially consider the possibility of assault when the woman's explanation of how an injury occurred does not seem plausible or when there has been a delay in seeking medical care. Common types of injury include:

◆ Contusions, abrasions, and minor lacerations, as well as fractures or sprains.

◆ Injuries to the head, neck, chest, breasts, and abdomen.

◆ Injuries during pregnancy.

◆ Multiple sites of injury.

◆ Repeated or chronic injuries.

Medical findings: The stress of living in an ongoing abusive relationship may cause any of the following:

◆ Chronic pain, psychogenetic pain, or pain due to diffuse trauma without visible evidence.

◆ Physical symptoms related to stress, chronic posttraumatic stress disorder, other anxiety disorders, or depression.

Examples are:

◆ Sleep and appetite disturbances.

◆ Fatigue, decreased concentration, sexual dysfunction.

◆ Chronic headaches.

◆ Abdominal and gastrointestinal complaints.

◆ Palpitations, dizziness, paresthesias, dyspnea.

◆ Atypical chest pain.

◆ Gynecologic problems, frequent vaginal and urinary tract infections, dyspareunia, pelvic pain.

◆ Frequent use of prescribed minor tranquilizers or pain medications.

◆ Frequent visits with vague complaints or symptoms with out evidence of physiologic abnormality.

Many practitioners have noted that chronic illnesses such as asthma, seizure disorders, diabetes, arthritis, hypertension, and heart disease may be exacerbated or poorly controlled in women who are being abused.

Sexual coercion and assault are common expressions of domestic violence. Assessment for sexual abuse and rape should be addressed in the sexual or social history taken during routine primary care visits, in discussions of birth control and safer sexual practices and in evaluations during gynecologic and obstetric visits.

Pregnancy:

Because of the risk to the mother and fetus, assessment for abuse should be incorporated into routine prenatal and postpartum care.

Presentation include:

◆ Injuries, particularly to the breasts, abdomen and genital unexplained pain.

◆ Substance abuse, poor nutrition, depression, and late or sporadic access to prenatal care.

◆ "Spontaneous" abortions, miscarriages,

and premature labor.

Mental Health/Psychiatric Symptoms:
Assessment for domestic violence should be included as a routine part of psychiatric intakes and evaluations. The stress of domestic violence may aggravate comorbid psychiatric disorders. Psychiatric symptoms of abuse include the following:

- Feelings of isolation and inability to cope.
- Suicide attempts or gestures.
- Depression.
- Panic Attacks and other anxiety symptoms.
- Alcohol or drug abuse.
- Posttraumatic stress reactions and/ or disorder.

Routine assessment of domestic violence in the patient's family is important for both men and women in alcohol and drug rehabilitation programs. Nearly 75% of all wives of alcoholics have been threatened, and 45% have been assaulted by their addicted partners.

Control in a Relationship:
An abusive partner's use of control within a violent relationship may result in:

- Limited access to routine and/or emergency medical care.
- Noncompliance with treatment regimens.
- Not being allowed to obtain or take medication.
- Missed appointments.
- Lack of independent transportation, access to finances, ability to communicate by phone.
- Failure to use condoms or other contraceptive methods.
- Not being told by a partner that he is infected with HIV or other sexually transmissible diseases.

Behavioral Signs:
Battered women exhibit a variety of responses to the stress of ongoing abuse; such patients may appear frightened, ashamed evasive or embarrassed. A battered woman may believe she deserves the abuse because the abuser tells her so, and she may take responsibility for his violence to maintain some sense of control over her situation. Other findings may include the following:

- Partner accompanies patient, insists on staying close, and answers all questions directed to her.
- Reluctance of a patient to speak or disagree in front of her partner.
- Intense irrational jealousy or possessiveness expressed by partner or reported by patient.
- Denial or minimization of violence by partner or by patient
- Exaggerated sense of personal responsibility for the relationship, including self-blame for her partner's violence.

Interventions

Important Considerations

Once abuse is recognized, a number of interventions are possible, but even if a woman is not ready to leave the relationship or take other action, the physician's recognition and validation of her situation is important. Silence, disregard, or disinterest convey tacit approval or acceptance of domestic violence. In contrast, recognition, acknowledgment, and concern confirm the seriousness of the problem and the need to solve it. Optimal care for the woman in an abusive relationship also depends on the physician's working knowledge of community resources that can provide safety, advocacy, and support.

The injury or complaint that precipitated the health care encounter requires evaluation and appropriate treatment. In addition, the physician should ask about the patient's use of pain, sleeping, or anti-anxiety agents. Psychiatric problems, including severe depression, panic disorder, suicidal tendencies or substance abuse, may hinder the battered woman's ability to assess her situation or take appropriate action. When serious psychiatric conditions are present, and appropriate treatment plan includes psychiatric evaluation and treatment. On the other hand, emotional, behavioral, and cognitive symptoms of abuse can be misinterpreted as psychiatric in origin. Physicians must make sure that the mental health professional to whom they refer the patient is sensitive to these issues.

Alcohol or drugs may be used to rationalize violent behavior. Perpetrators and family members may insist that substance abuse is the problem. Evidence indicates that while substance abuse and violent behavior frequently coexist, the violent behavior will not end unless interventions address the violence as well as the addiction. Similarly, mental illness is rarely the cause of domestic violence, although mental illness in a batterer can lead to loss of control and increased frequency and severity of violence. Treating the mental illness alone will not end the violence. Both issues must be addressed.

Couples' counseling or family intervention is generally contradicted in the presence of domestic violence. Attempts to implement family therapy in the presence of ongoing violence may increase the risk of serious harm. The first concern must be for the safety of the woman and her children.

Often women and not the only victims at home: Child abuse has been reported to occur in 33% to 54% of families where adult domestic violence occurs. In situations when children are also being abused, coordinated liaisons between advocates for victims of domestic violence and child protective service agents should be used to insure the safety of both the mother and her children. Otherwise, the reporting and investigation of alleged child abuse may increase the mother's risk of abuse.

Patient Safety

It is imperative that the physician inquire about a battered woman's safety before she leaves the medical setting. The severity of current or past injury is not an accurate predictor of future violence, and many

women minimize the danger they face. After assessing the situation, plans for the woman's safety should be discussed before she leaves the physician's office. Various options should be considered:

- Does she have friends and family with whom she can stay?
- Does she want immediate access to a shelter?
- If none is available, can she be admitted to the hospital?
- If she doesn't need immediate access to a shelter, give her written information about shelters and other re sources if it is safe to do so.
- Does she need immediate medical or psychiatric intervention?
- Does she want immediate access to counseling to help her deal with the stress caused by the abuse?
- Does she want to return to her partner, with a follow-up appointment at a later date?
- Does she need referrals to local domestic violence organizations?

Information & Resources

If the patient feels it is safe to do so, provide her with written information (including phone numbers) on legal options, local counseling and crisis intervention services, shelters, and community resources. In addition, educational materials on domestic violence in waiting areas and examination rooms may help patients identify violence as a personal health problem.

National organizations on domestic violence and many local and state battered women's programs have information available for use in physician offices. The National Domestic Violence hot line (800-333-SAFE) is a 24-hour resource to help women find local shelters. Counselors speak Spanish as well as English. The National Woman Abuse Prevention Center (202-857-0216) publishes fact sheets on domestic violence, a quarterly newsletter, and a series of brochures. Some of the material is translated into Spanish and Polish. The American College of Obstetricians and Gynecologists (202-863-2518) publishes "The Abused Woman," a publication for patients. The Family Violence Prevention Fund (415-821-4553) provides direct services to victims and develops public policy and training programs.

Local domestic violence shelters and statewide domestic violence programs are frequently listed in the phone book. They can help with housing, information about legal rights, welfare applications, and counseling (including peer groups and counseling for children). They may have brochures for distribution to women patients that address issues and list local resources. Many programs offer these services without charge.

Barriers to Identification

Patient Barriers

Many women are reluctant or unable to seek help. Some are literally held captive and not allowed out of the house. Others may not have money or means of transportation. If they do come to a physician's office, they may have to leave before they are seen, rather than risk further abuse for "getting home late." Childhood experiences of physical or sexual abuse, or witnessing domestic violence, may make it more difficult for a battered woman to recognize a relationship as abusive and to take steps to protect herself. Cultural, ethnic or religious background may also influence a woman's response to abuse and her awareness of viable options. Other reasons for not mentioning abuse include:

- Fear that revelation will jeopardize her safety.
- Shame and humiliation at the way she is being treated.
- Thinking she deserved the abuse and is not deserving of help.
- Feeling protective of her partner. He

may be her sole source of love and affection when he is not abusive and may provide the financial support for her and her children.

◆ Lack of awareness that her physical symptoms are caused by the stress of living in an abusive relationship.

◆ Belief that her injuries are not severe enough to mention.

Because the experience of abuse is so degrading and humiliating, a woman may be reluctant to discuss it with someone who may not take her seriously, who may discount her experience, who may perceive her as deserving the abuse, or blame her for staying with the abuser. She may fear that reporting the abuse will jeopardize her safety and destroy her means of support; she may stay in the relationship hoping that the situation will improve. Her partner may not always be abusive and this gives her hope that he will change.



Physician Barriers

Until recently, physicians rarely addressed issues of abuse and violence, even when the signs or symptoms were present. There are many reasons why physicians may avoid asking about abuse and why it may seem difficult to do so initially. Among these are:

◆ Lack of awareness of the prevalence, means of identification, or severity of the problem and lack of recognition of the social and psychological costs of abuse.

◆ Thinking it is not a physician's place to intervene, or that the woman must have provoked the abuse.

◆ Believing identification of abuse and referral for services is not part of the physician's role.

◆ Not knowing how to intervene or help even if a woman is recognized as being battered.

◆ "Blaming the patient" and feeling frustrated or angry if the womandoesn't leave her partner (She becomes the problem for being noncompliance with the physician's timetable).

◆ Disbelief because the alleged assailant is present and seems very concerned and pleasant.

◆ Concern that discussing psychosocial issues will take an overwhelming amount of time.

◆ Difficulty dealing with the feelings evoked by listening to a woman describe what has been done to her.

The physician may feel helpless or inadequate if he or she can't "do something" to "fix" the situation.

Documentation

Thorough, well-documented medical records are essential for preventing further abuse. Furthermore, they provide concrete evidence of violence and abuse and may prove to be crucial to the outcome of any legal case. If the medical record and testimony at trial are in conflict, the medical record may be considered more credible. Records should be kept in a precise, professional manner and should include the following:

- Chief complaint and description of the abusive event, patient's own words whenever possible rather than the physician's assessment. "My husband hit me with a bat" is preferable to "Patient has been abused."
- Complete medical history.
- Relevant social history.
- A detailed description of the injuries, including type, number, size, location, resolution, possible causes, and explanations given. Where applicable, the location and nature of the injuries should be recorded on a body chart or drawing.
- An opinion on whether the injuries were adequately explained.
- Results of all pertinent laboratory and other diagnostic procedures.
- Color photographs and imaging studies, if applicable.
- If the police are called, the name of the investigating officer and any actions taken.



LEGAL DEVELOPMENTS

Protection of Victims

Every state has laws designed to offer protection to victims of domestic violence. Some states have placed additional duties on police, requiring them to make arrests in certain cases, accompany women to their homes to collect children and belongings, and inform them of their legal rights. However, despite the increased interest in domestic violence and the enhanced availability of legal remedies, compliance with or enforcement of the laws on the part of some physicians, police, prosecutors, government agencies and courts is often less than ideal. Physicians need to be aware of state laws and of the services available in their community for abuse victims.

Mississippi Domestic Abuse Laws

The "Protection from Domestic Abuse Law" was enacted by the Mississippi Legislature in 1981. This law seeks to protect spouses, former spouses, persons living as spouses, parents and children from acts of abuse by present or former family members. An act of "abuse" under the law is attempting to cause or actually causing bodily injury; placing one under fear of bodily injury by physical menace or threat; or criminal sexual conduct committed against someone age 18 or under. The state Chancery Courts are responsible for administering the domestic abuse laws. If no Chancery Court is available, then either the Justice or County Court has jurisdiction. A victim of domestic abuse may seek the relief available under the act by filing a petition with the court citing the facts and circumstances surrounding the abuse. The types of relief available to the victim are in the form of "protective orders", which may include:

- directing the defendant to refrain from abusing the victim;
- granting exclusive possession of the household to the victim, by evicting the defendant;
- awarding temporary custody of any minor children;
- ordering the defendant to pay monetary compensation for injuries to the victim; and/or
- prohibiting the transfer, encumbrance or disposal of property owned by both the defendant and the victim.

The penalties for violating a protective order of the court are confinement in jail for up to six months and/or a fine of not more than $1,000.

Emergency Situations

Local law enforcement officers have been specifically granted the ability to respond to requests for assistance whenever a person alleges that he or she or his/her minor child has been the victim of domestic violence. In such instances, law enforcement must take whatever steps are reasonable necessary to protect the person from harm and advise him/her of sources

of shelter, medical care, counseling and other services. When requested by the victim, law enforcement must accompany him/her to their residence to obtain such things as food, clothing and other necessary articles and transport them to the nearest public or private shelter if feasible.

Reporting Abuse

Few states have explicit mandatory reporting laws for domestic abuse, and it is not clear that mandatory reporting would best ensure the safety of competent adult victims or connect them with needed resources. In Mississippi, whether or not a physician is required to report instances of abuse depends on whether the victim is an adult or a child.

Adults - a physician is not required to report cases of suspected abuse of adults, although he may certainly do so. If a report is made it should be submitted to the local Department of Human Services and any physician who chooses to make such a report is presumed to have acted in good faith and is immune from any civil or criminal liability which might have otherwise been incurred in making such a report. *Disclosure of a diagnosis of abuse to partners or any third party and the authorities should only be done with the victim's knowledge and consent.*

Minors - Mississippi law requires a physician who has reasonable cause to suspect that a patient who is age 18 or under has been battered or abused to orally report the situation immediately to the local county Department of Human Services office. A written report should subsequently be made as soon as possible. The reporting of an abused child does not constitute a breach of confidentiality and any physician who makes such a report is presumed to have acted in good faith and is immune from any civil or criminal liability for having made the report.

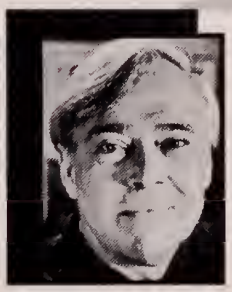
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Join the National Coalition of Physicians Against Family Violence

To link your group with interested physicians and medical societies across the country, the AMA has formed a National Coalition of Physicians Against Family Violence.

The coalition can keep your organization informed about model programs, resources, speakers and public education materials. You'll have access to newsletters and other publications on anti-violence programs and activities.

When you join the coalition, you will receive copies of the new AMA Diagnostic and Treatment Guidelines on Child Physical Abuse and Neglect, Child Sexual Abuse, and Domestic Violence. The Elder Abuse guidelines will be sent when available.

Coalition members will also receive a frameable certificate and a family violence poster.

Take Advantage of Family Violence Resources

The AMA is establishing a National Medical Resource Center on Family Violence. Its purposes are to:

- Provide information and technical assistance in preventing, identifying, diagnosing and treating family violence;
- Train professionals in the field of family violence; and
- Identify, verify and disseminate the best practices and treatment models.

Join the Coalition Today—

It costs nothing to join the coalition—just your commitment to help curb family violence.

When you enroll, be sure to list any areas where you would like assistance from the AMA.

How to Reach Your Three Audiences

Your organization has three primary audiences: the community, your membership, and the media. This handbook focuses on ways to maximize your anti-violence efforts with each.

You can make the strongest impact by working with the existing resources in your community. For optimum results, everyone involved in local efforts against family violence should work in cooperation.

But first you need to organize your own group's forces. And a good way to do that is with a Violence Prevention Committee.

Editorials represent the opinions of the authors and THE JOURNAL and not those of the American Medical Association.

Physicians and Domestic Violence

Can We Make a Difference?

During the past 4 years, the American Medical Association (AMA) has made diagnosis and prevention of family violence one of its top public health priorities. The AMA's definition of family violence includes child physical abuse, child sexual abuse, domestic violence or spousal abuse, and elder abuse as the four components—together a major public health problem. While previous AMA policies have sought to deter aspects of family violence, no concerted effort was made until a presentation at the AMA National Leadership Conference by the Board of Trustees in 1991. The overwhelming effect of that presentation led to a survey on the extent of domestic violence and the proper way to control it.[1] Among the findings:

- Three fourths of all Americans see violence as a very serious problem, and 40% believe family violence is a very serious problem in this country.
- More than 85% of Americans felt they could tell a physician if they themselves had been a victim or a perpetrator of family violence. This is slightly more than were willing to tell their priest, pastor, or rabbi and is considerably more than wish to tell a police officer.
- More than half of respondents felt that physicians could offer some help in controlling or reducing the amount of family violence.

Given that compelling challenge, the AMA Board of Trustees in October 1991 reported the creation of The Physicians' Campaign Against Family Violence. The goals of this campaign were twofold—to identify family violence as a public health problem and thus increase patients' comfort in discussing it with their physicians and to provide physicians with both the information needed to make an accurate diagnosis and a range of treatment alternatives for victims of abuse. To address these goals, diagnostic and treatment guidelines for the four major areas of family violence were developed. Every physician in this country was invited to join the Coalition of Physicians Against Family Violence, a nationwide network of practicing physicians who share treatment information and resources via national newsletters and other communications media. To date, more than 6000 physicians have joined this coalition, and it remains open to all physicians who wish to participate.

In January 1992, the entire first issue of *American Medical News* was dedicated to the problems of family violence. Positive reader response and requests for additional copies were unprecedented in that publication's history. Under the leadership of Dr George Lundberg and Dr C. Everett Koop, *JAMA* devoted two complete issues to interpersonal violence in June 1992. In addition, all nine AMA *Archives* journals concurrently dedicated all or most of their pages to the phenomenon of violence and trauma in our society. A compendium of all these articles entitled *Violence* is available.[2] This current issue of *JAMA* indicates a continuing effort to further this public health agenda.[3]

In 1992, the AMA formed a National Advisory Council on Family Violence. Comprising more than 40 medical specialty societies, the Council meets periodically to develop policy and program initiatives. The long-standing commitment of many specialty societies to combat violence has been most helpful in creating joint policies of prevention, education, and intervention.

In March 1994, the AMA joined the American Bar Association (ABA) and nearly 100 other national groups in presenting the National Conference on Family Violence: Health and Justice. More than 400 people participated in this working conference that dealt with not only the health but also the justice side of the problem of family violence. The 12 recommendations from the conference stress the importance of primary prevention through education and attitudinal changes, identification of survivors in families at risk, and early intervention designed to protect survivors, to hold abusers accountable for their behavior, and to demand the participation of abusers in rehabilitation programs. A recurring theme throughout the recommendations is the importance of forming truly multidisciplinary family violence coordinating councils to guide policy, prevention, and interventions at the local level. These councils would include not only judges, police, prosecutors, and other justice professionals, but also social services and shelter staff, health professionals, clergy, survivors, and other concerned citizens and members of the state coalitions against domestic violence. *The Guide for Communities: Building an Integrated Approach to Reducing Family Violence* will be published in 1995. The guide will serve as a practical tool to help communities implement the recommendations from the conference and will be distributed at a series of regional meetings to be held during 1996 and 1997. It is anticipated that the regional conferences will train state teams of professionals including those from the health, justice, social service, advocacy, and public policy fields. These teams will then return to their local communities using the developed strategies, information materials, and pilot programs that seem to be most effective in improving diagnosis, intervention, and treatment for victims of family violence. The continuing cooperation and interest of the ABA and its state affiliates have been outstanding and will enable future programs to have even greater impact. The AMA is similarly privileged to have been asked to participate in the ABA's current initiative, the Commission on Domestic Violence.

Throughout this effort, state medical associations have been extremely supportive. Most associations have developed their own family violence initiatives and/or standing committees, and many have published articles about their activities. In addition, the AMA Alliance—a nationwide volunteer organization of physician spouses—has been an active participant and leader with a variety of innovative programs to enhance this agenda. Last year alone, more than 600 programs were sponsored and produced by the Alliance across this country. The use of innovative

Dr McAfee is President, American Medical Association.
Reprint requests to American Medical Association, 515 N State St, Chicago, IL 60610 (Dr McAfee).

tools, such as coloring books that show preschool and early school children they can choose a nonviolent alternative, will continue to be an important part of these initiatives. In addition, the Alliance's new national program, SAVE—Stop America's Violence Everywhere, will further expand its already immense contributions. Their leadership, enthusiasm, cooperation, and commitment are crucial.

Throughout these initiatives, the AMA's House of Delegates has adopted policy statements related to a mass media violence rating system, firearm control, and the elimination of discrimination in the insurance industry for victims of family violence and received and published the numerous reports that have come from the Council on Scientific Affairs.[4-12]

The Joint Commission on Accreditation of Healthcare Organizations also has been helpful in allowing its standards and accreditation process to include the AMA's concerns about victims of family violence who come to a health care setting not only for injury treatment, but also for appropriate referral for intervention. These standards[13] are now an active part of its accreditation process and will be required of institutions that seek the commission's approval.

For the past 4 years, AMA representatives have testified in Washington, DC, on child abuse, television violence, motion picture violence and the need for a better violence rating system, video games and their effect on child behavior, domestic violence, elder abuse, and other aspects of violent behavior. The AMA has also met with the White House Domestic Policy Council, the US attorney general, and the secretary of health and human services. The cooperation and contribution of these administration leaders have been extremely helpful.

As a consequence of this concerted public health initiative, the AMA has had increasing opportunities to work with, or to participate in, the advisory committees of several major foundations and organizations. These organizations include the Centers for Disease Control and Prevention, the Commonwealth Fund, the Milbank Memorial Fund, Ford Foundation, Hilton Foundation, Robert Wood Johnson Foundation, Pew Foundation, and the Family Violence Prevention Fund. In addition, we have cosponsored and participated in programs with Physicians for a Violence-Free Society and Physicians for Social Responsibility.

As the root causes of violence come to light, the AMA has held discussions with media representatives and continues to participate on committees advising the mass media and in MediaScope, an initiative that monitors violence on network broadcast and cable television. Acknowledgment of their role in assessing the impact of violence was evidenced by the cable television industry's recent weeklong antiviolence programming initiative.

The congressional passage of the Violence Against Women Act, with appropriate funding, has allowed creation of the Office of Violence Against Women—an initiative supported by the AMA. The funding grants from this agency have allowed local communities to develop ongoing programs.

The AMA's accomplishments are largely due to the industry and hard work of the members of its Department of Mental Health. The premature death of Marshall Rosman, PhD, the former department head, whose leadership in this area will always be remembered, will serve to motivate those of us who knew him to further his agenda. The current director, Larry Goldman, MD, and his able assistants, together with our Department of News and Information and Department of Science News, continue to serve us well. The Board of Trustees has continued to identify family violence as a major public health commitment of the organization in eac and every strategic planning session.

Despite the fact that crime in general is leveling off or de creasing in the United States, incidents of violent crime, tha is, homicide, rape, and armed robbery, especially involvin young people, continue to increase.[14] As I travel this country the reception to initiatives against family violence and violen crime has been overwhelmingly favorable. Opportunities to in teract within the federation, within communities of large an small audiences, as well as with newspaper editorial boards an local media have emphasized what physicians as a group can d when confronted with a problem that significantly affects thei patients' health. The problem remains immense, and whil much of societal violence lies outside medical practice, there re mains a major role, if not a responsibility, for all physicians t prevent our young from learning violence as acceptable behav ior and to intervene where violence is causing physical and emo tional injuries to our patients.

Can we make a difference? I am reminded of a story that is tol in Maine of a stranger walking a beach at noon on a brilliant sunny day. As the tide has receded, a large number of starfis have been stranded on the hot sands, baked by the noonday sun They surely will not survive until the next tide returns. An olde woman skitters about the beach, gently picking up the starfis and tossing them back into the ocean. As the stranger ap proaches and notices the tens of thousands of starfish on the mile of sandy beach, he stops to ask the woman, "How can you possibly think that you are making a difference, with the vast number o starfish that are stranded?" The woman replies, gently pickin up a starfish next to her and showing it to the stranger, "For thi starfish, it makes all the difference in the world."

The AMA can bring its organizational resources to bear o a national agenda through its publications, its Coalition Agains Family Violence, its advocacy in Washington and in the courts and the sponsorship of regional and national programs. How ever, the true success of our commitment will come when w as physicians, treating patients one at a time, make a differenc by breaking the cycle of violence that engulfs people's lives.

Robert E. McAfee, MD

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American Medical Association

Physicians dedicated to the health of America

Robert E. McAfee, MD
Board of Trustees

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Dear Communicator:

Violence is in our midst -- from the school child suffering physical or sexual abuse, to the battered woman, to the elderly person injured by a family caregiver.

Too often, victims of family violence suffer in silence. Now you can help end that silence. You can help victims reach out to caring professionals; and you can help prevent the cycle of family violence from continuing into the next generation.

The first step is to educate yourself. As a surgeon, I'm still learning to take off the blinders I'd worn for so many years. I'm learning to see my patients in a new light. I'm learning to ask the right questions when a patient comes to me with minor injuries, but great anxiety.

I'll never forget the day I met Kevin Fullin, MD, a Kenosha, Wisconsin, cardiologist who helped develop a hospital-based domestic violence advocacy program.

"I understand you treat battered women," I said to him as we were introduced.

"And so do you," was Dr. Fullin's reply.

Domestic violence strikes one in four American families. It touches your neighbors, your colleagues, perhaps even someone close to you.

For too many years, family violence was shrouded in secrecy. Victims were too embarrassed, too frightened, too ashamed to tell anyone about the horrors of their private lives.

Traditional medical education taught how to treat the victim's black eye, the broken bones, the concussion -- but not how to look beyond the injuries for the underlying cause.

Now all that is changing. The American Medical Association recognizes family violence as a deadly public health crisis. Physicians see its victims every day, and are in a crucial position to help stop the cycle of violence.

AMA research shows that 80 percent of Americans feel they could tell a physician if they had been either a victim or a perpetrator of family violence. The patient's trust is there. What's needed are the right tools for the physician.

That's what the AMA Physicians' Campaign Against Family Violence is all about. Our series of four medical guidelines aims to help physicians ask the right questions, look beyond the physical symptoms, and identify and treat victims of family violence.

To succeed, the campaign needs your grassroots support. The people in your community need to know they can talk with their doctor about family violence; and physicians need your help in knowing where to refer victims in your community.

I urge you to become aware of, and get involved in, local efforts against family violence. This handbook is designed to help medical societies, auxiliaries, medical student sections and other groups work with community family violence resources.

I also encourage you to join the AMA's National Coalition of Physicians Against Family Violence. Your coalition membership will link you to concerned physicians and medical societies across the country, and give you access to model programs, resources and valuable materials.

The challenge is great. Only by working together can we make the American home a safe place for all of us.

Sincerely,

Robert E. McAfee, MD

The Surgeon General of the
Public Health Service
Washington DC 20201

Dear Medical Society Communicator:

Violence has reached epidemic proportions as a public health problem in America. It takes many forms and affects Americans at every age and every stage of life. In fact, about half of all homicide victims are killed by people they know.

More than two million cases of child abuse and neglect are reported each year, and we know many more are not reported!

This is family violence, violence that occurs between people who are intimate with each other.

Many American children are born into violence. They are subject to violence in their cribs. They are neglected due to turmoil in their homes. They are sexually abused. In fact, most sexual abuse of children is perpetrated by family members.

Early childhood experience has a lifetime impact. And where violence is concerned, it is a tragic one. As Surgeon General, I have made a point of urging community groups to help repair the lives of these children and their parents.

That is why I am concerned about violence against women. Too many women live in violent situations; more than a third of the women murdered in America are killed by their husbands or boyfriends.

So many women seek medical attention for injuries resulting from domestic violence. And beyond the human cost, there lurks an enormous monetary cost. Estimates from the National Crime Survey put the annual medical cost of domestic violence at almost 100,000 days of hospitalization, almost 30,000 emergency room visits, and almost 40,000 visits to a physician each year.

The medical cost of family violence begins to look even higher when we see that as many as 35 percent of women who visit hospital emergency rooms are there for symptoms related to ongoing abuse. Yet, as few as five percent of domestic violence victims are identified as such.

Because of the ongoing nature of family violence, many of these women will need medical attention over and over again.

As a society, we have not responded with the intensity needed to deal with such a menace to public health.

Yes, there are many caring, compassionate and competent professionals and volunteers who dedicate enormous time and effort to the problem of domestic violence. But society as a whole does not really acknowledge how bad the problem is.

We have a saying where I grew up: "Don't hold up your hand to block the sky and avoid the truth." The truth is, family violence is an epidemic in America today.

America's doctors are on the front lines in dealing with the consequences of violence, and must now be on the front lines in recognizing, treating and preventing it.

Physicians have played a vital role in the movement to prevent and treat victims of child abuse. Yet we have had only minimal involvement in addressing other forms of family violence, such as sexual abuse, domestic violence and elder abuse.

Now the American Medical Association is doing something -- something positive, constructive and comprehensive -- something to enable doctors to make significant contributions to dealing with family violence.

That is what the AMA Physicians' Campaign Against Family Violence is all about. And its success depends on your support. I urge your medical society to get involved in your community's efforts against family violence.

You are in a pivotal position to reach the medical community, the media and the public. Your efforts today will make a difference in the future of America.

Sincerely,

Antonia Novello, MD, MPH

ENROLLMENT FORM

Please enroll me in the AMA National Coalition of Physicians Against Family Violence.

Name _____

Title _____

Professional Degree _____

Organization Name _____

Address _____

City _____

State _____ ZIP _____

Areas of interest within Family Violence:

_____ Child Abuse

_____ Sexual Abuse

_____ Domestic Violence

_____ Elder Abuse

_____ Other

Mail to:

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You will receive a frameable coalition certificate, a family violence poster, and copies of the new AMA Diagnostic and Treatment Guidelines on Child Physical Abuse and Neglect, Child Sexual Abuse, and Domestic Violence. Elder Abuse guidelines will be available in October 1992.

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Editorial

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VOLUME XXXVI, NUMBER 10
OCTOBER/NOVEMBER 1995

Second Opinion and More Sought for Description of Managed Care

Dr. Powell lived way up Waban Hill, where the really big houses were, and when I was a kid, I used to walk up there for my checkups.

He was my family doctor. He knew my name, he'd ask about my parents and he didn't mind spending time with a patient—not when he took the time to reassure an overimaginative 12 year-old that the white and sickly skin around a cut wasn't gangrene and that band-aids need to be changed from time to time. 'I know I should have asked my folks first before dropping by, but Dr. Powell didn't mind. He didn't bill us for that, either

I was thinking about Dr. Powell, who retired years ago, because of a letter I got the other day from a public relations person at a local health insurance company.

Objected to Newspaper Description

The insurer objected to a description The Times-Dispatch has been using for "man "managed care," which we've been describing as a kind of health plan that tries to cut costs by controlling when and how people get access to health care.

The PR person proposed, instead that we describe managed care as: "The term used to describe a health-care delivery system that emphasizes prevention and a personal relationship with one physician in order to provide more cost-effective medical care."

Managed care, the spokesperson added, provides easier access to health care and a choice of family physicians. A 1994 survey showed that 83 percent of HMO members were happy with their coverage, compared with 77 percent of people covered by traditional plans. That's a 6 percent point difference.

Doctor Picked From A List

Under my own managed care coverage, my family doctor is a corporation. We picked it because it was on a list the HMO gave us. Same with the managed care coverage my family had when we lived in Tidewater.

The Health Insurance Association of America—the trade association for health insurers—takes a couple of paragraphs to define managed care.

Its definition uses other jargon terms, but when-you look everything up, the key elements the association emphasizes are that a managed plan selects doctors and hospitals for its members to use, steers members to those doctors and hospitals, and tries to reduce unnecessary hospital admissions and control the length of stay for patients.

It doesn't say anything about preventive care or a family doctor relationship.

(Continued on page 356...Managed Care, please see Editor's note seeking your response.)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Editorial

(*Managed Care, continued from page 355*)

Nor does William M. Mercer Inc., a group that advises insurance companies and employers on health plans. Mercer defines managed care as a system that tries to control costs by managing utilization and price.

System Based on Limited Network

The Times-Dispatch definition derives from the fact that every variety of managed care is based on a limited network of doctors and hospitals, a set of rules for how to use them and a role for the insurer in saying what kind of care is or is not appropriate for a particular patient. Under managed care, the person the doctor consults before sending you to a hospital is an insurance company employee.

But not every kind of managed care necessarily involves a family doctor relationship with a single physician. Nor do other ways of paying for health care necessarily rule that relationship out.

The same goes for preventive care.

The goal of managed care plans may very well be satisfied customers who are in better health.

But surely that is the goal of everyone in health care?

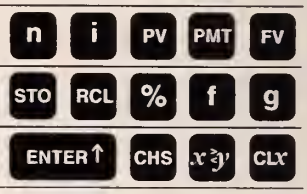
David Ress
Finance Columnist
Richmond Times-Dispatch

Editor's Note: JOURNAL MSMA would like to print your description of managed care. From your experiences, how do you feel managed care should be defined? Write us at P. O. Box 5229, Jackson, MS 39296-5229. A future issue of JOURNAL MSMA will

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D. Stanley Hartness, Jr., MD

The President's Page

Election '95: A Box of Chocolates?

Unless you've been living on another planet, you don't have to be reminded that this is an election year. The extent to which each of us has chosen to participate in these elections will determine what state government does for or to us the next four years.

As the two beleaguered congressmen strode down the steps of the Capitol, one turned to the other and confessed, "I'm down to only one PAC a day." Fortunately for us, MSMA is also down to one PAC.

That great philosopher Lyndon Johnson once declared rather simplistically, "If you're in politics, and you can't tell when you walk into a room who's for you and who's against you, then you're in the wrong line of work." Our own Mississippi Medical Political Action Committee (MMPAC) has been hard at work trying to determine just that.

Chaired by Dean Cromartie of Hattiesburg, MMPAC is composed of two physician members and an alternate from each of the five congressional districts as well as two Alliance members and an alternate. Serving as government affairs staff person is Bill Roberts whose insightul expertise has proved invaluable.

MMPAC has published a list of candidates which it has endorsed. You are encouraged to do whatever you can between

now and November 7 to support the recommended candidates in your area since the outcome of these elections will determine the success of our '96 legislative efforts. It has been said that the only difference between stupidity and genius is that genius has its limits!

Of particular interest is the race for lieutenant governor. MSMA plans to push for tort reform during the next legislative session, and incumbent Lt. Gov. Eddie Briggs looked your board in the eye and pledged to support such reform in medical malpractice cases by referring to "a favorable committee" any bill introduced setting a cap on non-economic damages and/or establishing a statute of repose for malpractice cases. In this instance, the familiar "A friend in need is a friend indeed" works both ways.

This is no time for MSMA members to sit idly on the sidelines watching the elections pass us by. Election '95 does not have to be like Forrest Gump's box of chocolates: The implications for future Mississippi physicians of an educated electorate supporting medically informed candidates cannot be overstated. Mark Shields, noted television commentator, has said it quite eloquently, "We have been warmed by fires we did not build; we have been filled by springs we did not dig; we can do no less for those who come after us."

Stanley

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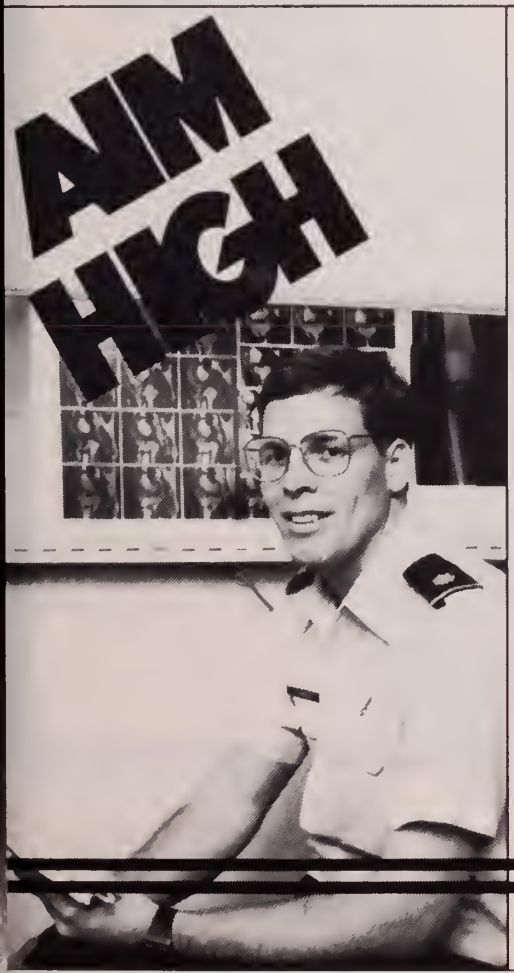
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Mississippi Foundation for Medical Care

As the Peer Review organization (PRO), the Foundation utilizes its data collection and analysis expertise to compare medical practice in the state to national guidelines or practice standards. This information is available for physicians and providers to improve quality of care.

Quality Improvement Projects Update

Influenza immunization-to increase the number of flu vaccinations given during hospitalization of Medicare patients, and to increase the knowledge of the need for this immunization.

Acute stroke care-to improve the care of stoke patients assuggested by recent practice guidelines.

Blood transfusion-to improve the use of blood transfusion as suggested by practice guidelines.

Antibiotics prior to surgery-to promote the proper usage of antibiotics as suggested by current practice guidelines to prevent postoperative infections.

Cardiovascular project-to improve care given to heart attack victims as suggested by recent practice guidelines.

Heart failure-to promote the usage of new medications which have been found to improve outcomes and reduce hospital readmissions for patients with certain types of heart failure.

Diabetes-to promote the usage of new medications that may reduce kidney failure in certain patients with diabetes. When used appropriately these medications may reduce the need for kidney dialysis and transplants.

Blood pressure treatment-to improve the treatment of high blood pressure in patients with acute stokes.

Breast cancer-to educate the public and enhance the use of mammography in Medicare patients for the early detection of breast cancer.

Coding-to improve the accuracy of the Medicare data base.

Quality Improvement Projects:

Use statistical methods to define projects from data; Compare existing practice to guidelines; Feedback information to providers; Identify areas for improvement in providing care; Assist providers in developing an improvement plan; Measure improvement.

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Dr. D. Stanley Hartness, Jr. *addressed the Northeast Mississippi Medical Society August 31, 1995 in Tupelo, MS.*

MSMAA Health Promotions Chairman Cathy Gersh *and* ***MSMAA President Jeanne Morrison*** *exhibited at and attended the March of Dimes/MSMA cosponsored conference, "Confronting Family Violence: Awareness, Attitude, Action, held September 28-29 at the Ramada Coliseum in Jackson.*



MSMA Alliance

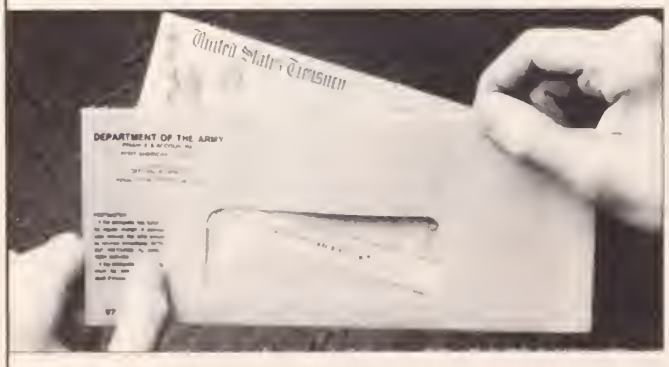
MISSISSIPPI STATE MEDICAL ASSOCIATION ALLIANCE
HEALTH PROMOTIONS REPORT
SEPTEMBER 7 , 1995 SUMMER BOARD MEETING
CATHY GERSH

In hopes of decreasing violence and preventing violence-related crimes and tragedies in Mississippi, the Mississippi State Medical Association Alliance Health Promotions Committee in conjunction with the Mississippi State Medical Association and the American Medical Association Alliance have launched a program called SAVE: STOP AMERICA'S VIOLENCE EVERYWHERE! The program is an extension of the Campaign Against Family Violence which was developed by the AMA Alliance in 1991. SAVE will be a year-round program with the goal of making an impact on the devastating social problem that robs so many Americans of quality living.

Beginning on October 1 1, 1995, the second Wednesday in October has been designated as the annual SAVE Today! Alliances across the state will be encouraged to implement at least one program to call attention to SAVE Today. Possible programs for SAVE may be as simple as getting the local mayor to proclaim October 11 as SAVE Today, a poster contest or distributing information to school children, or highway billboards with the SAVE message. Other programs could include educational seminars, walk-a-thons, fundraisers, or candle light vigils. We also plan to have Governor Fordice sign a proclamation for the state of Mississippi for SAVE Today . An exhibit on SAVE was displayed at the Family Violence Conference in Jackson on September 28th & 29th.

PHYSICIAN RESIDENT ALERT: IF YOU COULD USE OVER $25,000 A YEAR– ANSWER THIS AD.

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Under the direction of MSMA President Stanley Hartness, the alliance will be developing and distributing a booklet about Domestic Violence. This booklet will be a directory of the State of Mississippi's Domestic Violence shelters and will include protocols and treatment guidelines for physicians. This will be distributed to physician's offices and clinics across the state.

Health Choice '96 will once again be offered to the children of Mississippi. The goal this year is to increase the number of children reached by increasing the number of sites as well as the number of children in attendance at each location. We are encouraging county alliances to involve more children and have increased the number of sites to 8 locations to reach students in all areas of the state. Selected sites are Hattiesburg, Jackson, Columbus, Laurel, Singing River, Vicksburg, Tupelo and Gulfport! JeVon Thompson will once again be our featured speaker expanding on such ideas as anti-violent behavior, conflict resolution and gun safety awareness! Attention will focused on these issues to compliment our theme of SAVE! The tentative dates are March 18 - 22, 1996. It's important to help children grow up understanding that violence is not the answer to life's conflicts!

Gun Safety Awareness education and project ideas will also be presented to each county. Gun Safety Awareness Week is the 3rd week in April and we are currently looking into purchasing "Trigger Locks" for distribution to alliances in memory of Karen Stephens, MSMAA's immediate past president.

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BLACKWOOD, MARK E., Cleveland. Born April 13, 1963, Greenwood, MS; MD University of Mississippi School of Medicine, Jackson, MS, 1991; internship in family medicine, University Medical Center, Jackson, MS, one year; ob-gyn residency, University of Texas, Southwest Medical Center, Dallas, TX, 1992-95; elected by Delta Medical Society.

BONNER, CYNTHIA M., Tupelo. Born Tuscaloosa, AL, June 19, 1963; MD University of Alabama School of Medicine, Birmingham, AL, 1989; pediatric residency, University of Arkansas for Medical Sciences, Little Rock, AR 1989-92; neonatology fellowship, same, 1992-95; elected by Northeast Miss. Medical Society.

BORNE, MICHAEL J., Jackson. Born New Orleans, LA, January 19, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1989; internship, Baptist Medical Center, Birmingham, AL, one year; ophthalmology residency, Vanderbilt University Medical Center, Nashville, TN, 1990-93; fellowship in retina surgery, Willis Eye Hospital, Philadelphia, PA, 1993-95; elected by Central Medical Society.



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CROUT, JEFFREY D., Jackson. Born Jackson, MS, July 12, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; pediatric residency, University Medical Center, Jackson, MS, 1990-94; elected by Central Medical Society.

FORTIER-BENSEN, R., Gulfport. Born New Orleans, LA, May 5, 1954; MD Louisiana State University School of Medicine, New Orleans, LA., 1983; internship, USAMC, one year; anesthesiology & pain management residency, University of Alabama Medical Center, Birmingham, AL; elected by Coast Counties Medical Society.

ISAACS, JOHN D., JR., Jackson. Born Meridian, MS, March 28, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1989; ob-gyn residency, UMC, Jackson, MS, 1989-93; reproductive endocrinology fellowship, Washington University, St. Louis, MO, 1993-95; elected by Central Medical Society.

KING, PAUL, New Albany; Born New York City, NY, November 3, 1945; MD Cornell University Medical College, New York, NY, 1974; psychiatry residency, the New York Hospital at Cornell, NY, 1974-77; fellowship in child & adolescent psychiatry, 1977-79; elected by Northeast Miss. Medical Society.

LAURENZO, JOHN E., Oxford. Born Champaign-Urbana, IL, Sept. 17, 1964; MD Vanderbilt University School of Medicine, Nashville, TN, 1989; otolaryngology & head & neck surgery residency, University of Iowa Hospitals & Clinics, Iowa City, IA, 1989-94; elected by North Mississippi Medical Society.

LEADER, LAWRENCE JAY., Laurel. Born Miami, FL, Dec. 7, 1960; MD Southeastern College Osteopathic Medicine, No Miami Beach, FL, 1988; interned, one year, Wellington Regional Medical Center, Willington, FL; internal medicine residency, Yale University School of Medicine, Norwalk, CT, 1989-92; cardiology fellowship, Cooper Hospital, Camden, NY, 1992-94 & Deborah Heart & Lung Ct, Browns Mills, NJ, 1994-95; elected by South Miss. Medical Society.

SMITH, RONALD BLAKE, Oxford. Born Brookhaven, MS, December 28, 1962; MD University of Mississippi School of Mississippi, Jackson, MS, 1991; ob-gyn residency, University Medical Center, Jackson, MS, 1991-95; elected by North Miss. Medical Society.

STOUT, DAVID COLLINS, Hattiesburg. Born Baton Rouge, LA, February 6, 1961; MD Louisiana State University Medical Center, Shreveport, LA, 1990; interned one year, same;
urology residency, same, 1991-95; elected by South Miss. Medical Society.

TATE, CRYSTAL L., New Albany. Born New Albany, MS, June 5, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1992; family medicine residency, University Medical Center, Jackson, MS, 1992-95;

(continued on page 366)

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New Members

TOLER, KENNETH P., JR., Jackson. Born Greenville, MS, April 9, 1959; MD University of Mississippi School of Medicine, Jackson, MS, 1991; ophthalmology residency, University Medical Center, Jackson, MS, 1991-95; elected by Central Medical Society.

TREACY, STEPHEN H., Jackson. Born Naperville, IL, January 11, 1964; MD University of Illinois School of Medicine, Chicago, IL, 1990; orthopaedic surgery residency, Tulane University Medical Center, New Orleans, LA., 1991-95; elected by Central Medical Society.

VANCE, GREGORY ALAN, New Albany. Born New Orleans, LA., January 28, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1992; family medicine residency, University Medical Center, Jackson, MS, 1992-95; elected by Northeast Miss. Medical Society.

WASHBURNE, JOSEPH F., Hattiesburg. Born Delhi, LA, March 4, 1964; MD Louisiana State University School of Medicine, Shreveport, LA., 1991; ob-gyn residency, University Medical Center, Jackson, MS, 1991-95; elected by South Miss. Medical Society.

Deaths

COOK, CLAYTON S., Hattiesburg. Born Hattiesburg, MS, April 26, 1926; MD Tulane University School of Medicine, New Orleans, LA., 1949; interned Charity Hospital, New Orleans, LA, one year; general surgery residency, Mayo Foundation, Rochester, MI, 1952-56; practiced medicine for 38 years in Hattiesburg, MS; died August 13, 1995, age 69.

THOMAS, P.K., JR, Tupelo. Born Lee County, MS, January 1, 1919; MD Tulane University School of Medicine, New Orleans, LA., 1943; interned one year, University of Iowa, Iowa City, Iowa; ob-gyn residency, Lloyd Nolan Hospital, Birmingham, ALL. 1946-50; practiced medicine for 37 years in Tupelo and was instrumental for the growth of North MS Medical Center from a 50 bed hospital to one of over 800 beds today; died September 29, 1995, age 76.

Personals

Don Q. Mitchell, MD, of Jackson was re-elected treasurer of the American College of Allergy, Asthma and Immunology.

Ralph Daniel, III, MD has recently given talks on fungi and nail disorders in New York, Chicago, New Orleans, Orlando and Saudi Arabia.

Norman C. Nelson, MD, was honored last month by the National Multiple Sclerosis Society with a dinner given in his name.

Gene R. Barrett, MD, of Mississippi Sports Medicine and Orthopaedic Center was one of the key speakers on knee problems at a combined meeting of the Knee Society of Mexico and the Arthroscopy Association of North America recently in Mazatlan, Mexico. He also spoke on new techniques for meniscus repair and Anterior Cruciate Ligament reconstruction in athletes at the Brazilian Knee Society in Campinas, Brazil. He was the discussant of three basic science papers on meniscus healing and transplantation at the American Orthopedic Society for Sports Medicine in Toronto, Canada.

Paul M. Allen, MD, a gynecologist and obstetrician practicing in Pascagoula has been notified by Dr. Donald R. Ostergard, Managing Editor of the International Urogynecology and Pelvic Floor Dysfunction Journal, that a manuscript he submitted to that journal entitled The Female Urethral Syndrome is Rarely Associated with Human Papillomavirus Infection Types 6/11, 16, 18, 31, 33, has been accepted for publication. Dr. Allen was the lead investigator in this study and the lead author of this article. His co-investigators of this study and co-authors of this article were Drs' Gordon D. Davis of Phoenix, AZ, Larry W. Bowen of Sacramento, CA, Peter K. Sand of Evanston, IL, David B. Hebert of Slidell, LA and Edward J. Wilkinson of Gainesville, FL. Dr. Allen is CEO and Medical Director of Women's Center for Health Care on the coast.

Jaime Jimenez, MD, chief of diabetes and retina at Southern Eye Center, attended the Vitreous Society in London, England.

Arthur Guyton, MD, professor emeritus of physiolgy, has been awarded the Lifetime Achievement Award given by the Consortium of Southeastern Hypertension Centers. The award cited his major influence in cardiovascular research, especially hypertension. "He really changed the whole direction of hypertension research," said Dr. John Hall who succeeded Dr. Guyton as chaiman of the physiology department.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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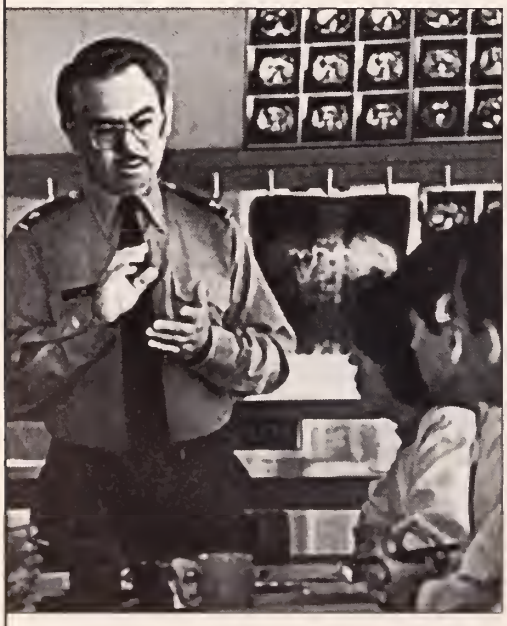
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Information For Authors

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted.** The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

Reviewing Process. Each manuscript is reviewed by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to Journal readers, and usefulness or importance to physicians. Authors are notified upon the acceptance or rejection of their manuscript. Accepted manuscripts become the property of the Journal and may not be published elsewhere, in part or in whole, without permission from the Journal.

Title Page should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

Abstract, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

Key Words should follow the abstract and be identified as such. Provide three to five key

words or short phrases that will assist indexers in cross indexing your article. Use terms from the Medical Subject Heading list from Index Medicus when possible.

Subheads are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials, Case Reports, Symptoms, Examination, Treatment and Technique, Results, Discussion, and Summary.

References must be double spaced on a separate sheet of paper and limited to a reasonable number. They will be critically examined at the time of review and must be kept to a minimum. All references must be cited in the text and the list should be arranged in order of citation, not alphabetically. Personal Communications and unpublished data should not be included in references, but should be incorporated in the text. The following form should be followed:

Journals

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A 12 Month Study Of Syphilis

Sexually Transmitted Diseases In A University Student Population

Virginia M. Crawford, M. D.
Carolyn T. Gerald, M. D.
Kim Henson, M.T., A.S.C.P.
Christopher Anderson

Although the real age of syphilis is unknown, it has been well described since at least the 16th century. The term first appears in the poem of Fracastorius (1530) as Syphilus, the name of a shepherd infected with the disease. With the advent of Penicillin in the 1940's the incidence of syphilis began to decline. Treponema pallidum, a pathogenic bacterium-like spirochete, has remained highly sensitive to Penicillin through the years and Penicillin is still the drug of first choice for syphilis treatment.

A review of **MISSISSIPPI MORBIDITY REPORT** published by the Mississippi State Board of Health reveals a dramatic resurgence of syphilis since about 1988 with rapidly increasing levels from 1990 and continuing to date. Quality review of our reportable Sexually Transmitted Diseases from the University of Southern Mississippi Student Health Clinic of the three years prior to 1993 did not reflect this parallel. The decision was made to undertake a 12 month study of our student population with the concern for ameliorating any risk of missed diagnoses.

The University of Southern Mississippi has a student population averaging around 12,000 to 14,000 in recent years which includes a diverse representation of racial, cultural, socioeconomic and ethnic backgrounds including many international students. The University of Southern Mississippi Student Health Clinic sees an average of 3,000 students per month.

This investigation was conducted through a prospective study with student volunteers practicing absolute patient confidentiality within the limits of required reporting of sexually transmitted diseases.

METHODS

Our study consisted of 110 subjects from our student population and covered a 12 month time period beginning January 1994 and ending in December 1994. Results were analyzed looking at patient age, sex, multiple versus single sex partners, positive chlamydia antigen tests, positive gonorrhea cultures, positive R.P.R. tests for syphilis, positive herpes

antibody based enzyme immunoassay and cultures, other positive STDs, human papillomavirus disease, pediculosis, monilial vaginitis and/or penile rash, and trichomonas. Other factors considered were Pap smears, genital symptoms or clinical findings suggestive of STDs, bacterial vaginosis, history of documented exposure to STDs, positive Hepatitis B (disregarding previous immunization and regarding only infection as a cause for positivity), and other interesting seemingly related information. For example, 5 subjects voluntarily identified themselves as being only involved in same sex relationships. An attempt was made to correlate abnormal Pap smears with other factors considered in the study.

Patients were selected for the study by identification of any of the above factors and offered a free test for syphilis after explaining the study fully. Patients had the option to participate voluntarily or decline. It is important to note that R.P.R.s were always drawn according to preset clinic protocol when clinically indicated and the patient NOT included in the study group if they declined. STDs health education counseling for patients and partners was a strong part of the study as was appropriate follow-up. Legal guidelines for reportable STDs were explained to the patients and followed. Again, strict patient confidentiality was maintained within the pre-explained guidelines of reportable diseases. The study protocol was presented to the University of Southern Mississippi Committee for Human Subject Research Review and adopted to receive their approval prior to its initiation.

DATA

The median age of our group was 23.60 with an age range of 19 years old to 51 years old. There were 22 males, 88 females, 51 Black students 54 Caucasian students of which 2 were Western European, 2 Hispanic students, 2 Asian/Oriental students, and 1 Asian/Middle Eastern student. Interestingly, only one student was found to have a positive R.P.R. and this represented old previously treated syphilis. No new cases were diagnosed. Other findings included 8 positive gonorrhea cultures, 20 positive tests for chlamydia, 9 positive tests for herpes progenitalis,19 patients diagnosed with human papillomavirus infection, and 24 abnormal Pap smears. There were 3 cases of scabies, 6 cases of pubic pediculosis, 39 cases of candidiasis, primarily vaginitis, and 5 cases of trichomonas vaginitis. The data included 27 cases of documented exposure to STDs, 23 cases of bacterial vaginosis, 4 students who volunteered the information that they involved in same sex relationships only, 56 students reported multiple sex partner history, 82 students had either symptoms or a clinical examination suspicious for STDs, 2 cases of positive Hepatitis B, 3 students had non-specific inflammatory arthritis/ arthralgia (not associated with a positive gonorrhea culture), and 3 students had a significant depression related to the positive diagnosis of either herpes progenitalis, human pappillomavirus infection or a positive test for chlamydia. One student withdrew from school due to this depression.

There appeared to be multiple factors related to sexual behavior and the patients' incidence of sexually transmitted diseases and an abnormal Pap smear. (See figure 1).

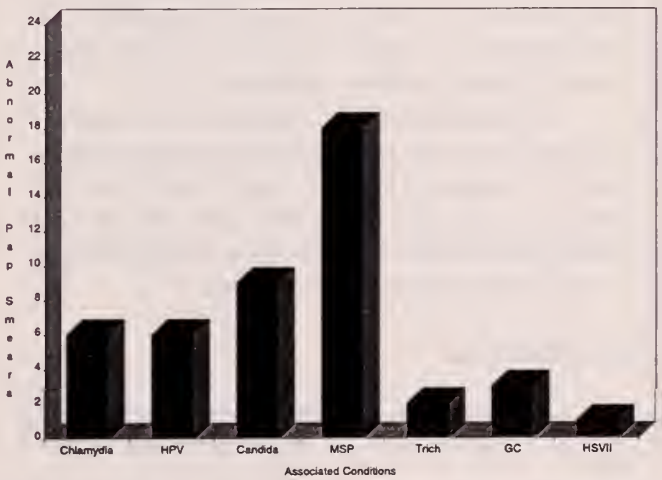


Figure 1: *Association of chlamydia, human pappillomavirus infection, candidiasis, history of multiple sex partners, trichomonas vaginitis, herpes simplex virus II, and positive gonorrhea culture with 24 abnormal pap smears.*
Chlamydia: Positive Chlamydia Antigen Test
HPV: Human Papillomavirus
Candida: Candidiasis, Primary Vaginitis
MSP: Multiple Sex Partners
Trich: Trichomonas Vaginitis
HSVII: Herpes Progenitalis
GC: Positive Gonorrhea Culture

CONCLUSIONS

Although our study revealed only one positive R.P.R., we felt the data compiled by our screening efforts was valuable. Incidently this is the only positive R.P.R. performed at our clinic in the past three years. Literature review suggests that the puzzling syphilis case numbers increase while not fully explained seems to be correlated with several factors. The invasion of rural areas by "crack cocaine" use and its "sex for drugs" - "drugs for sex" behavior partner as well as the increasing numbers of HIV/AIDS related illnesses are two suspected reasons. Alcohol continues to be the "drug of choice" among college students in our area and our recognized HIV positive population on campus is very small.

Another possible explanation for our low yield of syphilis cases may be the close proximity (about one mile away) of the Forrest County Health Department and its ease of accessibility to our students. While we will continue to be vigilant, the fear of missing diagnoses of syphilis has been alleviated.

Our rates of gonorrhea, chlamydia, and herpes progenitalis seem to parallel reported public health ratios. As suggested by other studies, multiple sex partners and sexually transmitted diseases, especially human pappillomavirus disease, is associated with an increased risk of abnormal Pap smears.

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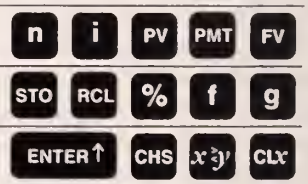
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Candida as a Nail Pathogen In Healthy Patients

C. Ralph Daniel, III, M.D.
Boni E. Elewski, M.D.

There is considerable controversy surrounding the role of Candida as a pathogen in the nail in immunocompetent patients. For example, some literature suggests that Candida is a common nail pathogen, especially in fingernails.[1,2,3] Other authors find Candida to be a relatively unimportant nail pathogen.[4] In this paper, we attempt to provoke thought and further study pro and against Candida being an important pathogenic agent of onychomycosis in healthy individuals.

Con
by C. Ralph Daniel, III, M.D.

Is Candida a primary pathogen of the nail in a non immunocompromised host? The answer to this question is unclear. In mucocutaneous candidiasis, AIDS, and other immunodeficiency disorders, we know that the organisms, especially Candida albicans, may be a primary pathogen.[5] Other Candida species including Candida tropicalis, C. parapsilosis, C. krusei, C. stellatoidea, and C. quilliermondii are less common primary pathogens as is the related Torulopsis (Candida) glabrata. Candida is more commonly found as a secondary pathogen in diabetics, obese individuals, in patients on systemic corticosteroids, antibiotics, and cancer chemotherapy, and with aging.

How do we establish Candida as a pathogen? Those of us that frequently culture nails[6] for fungi, often find C. albicans growing on Sabaraud's agar with chloramphenicol. Only C. albicans reliably grows on Mycosel or DTM agar. It is not unusual to find yeast upon doing a nail potassium hydroxide stain (KOH). It is quite uncommon to find pseudohyphae, or hyphae.

In our experience, especially in nails, if Candida is grown on culture but we do not observe pseudohyphae or hyphae upon doing a KOH or nail biopsy, then it is not treated as a primary pathogen. If the patient is immunocompromised or if the nails resemble those of chronic mucocutaneous candidiasis (CMCC), then further consideration may be given that the organisms are pathogens.

What is a primary pathogen? For the purposes of this discussion, it will be defined as an agent that primarily causes the clinical disease, and not just aggravates it.

It has been our practice to do fungal cultures and potassium hydroxide stains on all cases of onychomycosis, onycholysis, and chronic paronychia that present to us. In many cases, the genus, Candida grows. Is this clinically significant? For over ten years,

we have treated this result as being probably contributory, but not causative. It has been our experience with onycholysis and chronic paronychia with Candida growing on culture, that the trauma, contact irritants, etc., are usually the primary pathogen" in these cases. We feel that Candida worsens the problem. Basically, we treat simple chronic paronychia and simple onycholysis as follows: 1) try to eliminate the primary cause (usually contactant, trauma, etc.) 2) a strict general irritant avoidance regimen including no nail cosmetics and the use of vinyl and cotton gloves for wet work 3) keeping the involved nails short 4) decreasing subsequent trauma to the nail unit and preserving the integrity of the nail folds 5) topical antifungal solutions -- we use these for two reasons, even if Candida is not found by KOH or culture: a) drying effect b) to diminish existing Candida or decrease the chance of future Candida colonization, both of which may exacerbate the disorder. There are, of course, many more causes of chronic paronychia[7,8] and onycholysis.[9,10] It is infrequent that we have to use systemic antifungals for these two conditions. Hay is of a similar opinion.[2] Oral itraconazole, ketoconazole, or fluconazole may be used when necessary but are not FDA approved for this indication in the United States.

To reiterate, it is our firm opinion that chronic paronychia and onycholysis are only rarely caused by Candida. It is felt that Candida may worsen these disorders.

Dr. Elewski presents further data from the Middle East and elsewhere that suggests that Candida may play a more direct role in onychomycosis in healthy patients.

Pro
by Boni E. Elewski, M.D.

As Candida is endogenous, a positive culture, is difficult to assess, resulting in controversy in its role as a pathogen. For example, when evaluating the oral cavity, a positive culture is of little value without appropriate clinical findings and microscopy, because Candida can be recovered from the mouth of 30% of healthy adults.[11] Likewise, a positive culture of C. albicans from the nail may also be disregarded without appropriate clinical observations and positive microscopy.

When and how often does Candida cause onychomycosis?

That Candida albicans can invade the nail unit is definitely proven in the patient with chronic mucocutaneous candidiasis (CMCC). There is additional evidence from the Middle East where Candida albicans has been reported to cause interdigital foot involvement and onychomycosis.[12] According to Al-Sogair et al, Candida produces cutaneous manifestations indistinguishable from the dermatophyte, Trichophyton rubrum, even hyperkeratotic lesions with one hand and both feet have been reported. Of 4,294 patients with apparent tinea pedis manuum from Saudi Arabia 88.9% were caused by Candida and dermatophytes accounted for only 11.1%. The patients infected with Candida had a variety of presentations including interdigital lesions, hyperkeratotic scaly lesions and inflammatory lesions. Of those with hand involvement, Candida albicans was the only species of Candida implicated; however, other species of Candida were found in several patients with interdigital foot involvement. The authors, however, did not address the possibility of Candida being a commensal, in at least some of these patients, which may question the validity of this study. The explanation for this proposed high incidence of Candida in the Middle East is unknown. However, the occurrence in this predominantly Muslin region may be accounted for by the religious ritual of washing feet several times daily, which can cause maceration and loss of epidermal integrity, risk factors for cutaneous candidiasis. Alternatively, a selective immunological defect in this population may explain these findings.

In Summerbell's epidemiologic study[4] of 2,662 patients with onychomycosis, from Canada, 5.5% were caused by Candida albicans. No other yeasts were found to be pathogens in this study. Other studies have found an even higher incidence of Candida in nail isolates. There are inherent problems in conclusively proving non-Candida albicans strains as nail pathogens. For example, Candida albicans can be documented microscopically by the presence of pseudohyphae, hyphae and yeast cells. With the exception of C. tropicalis, other species of Candida generally appear as yeast cells without pseudohyphae or hyphae on direct microscopy, and are as a consequence more difficult to identify, generally requiring biochemical tests for confirmation.

In addition to CMCC, there are three varieties of Candida onychomycosis reported in the literature, but these are not accepted by all authorities. Firstly, is a periungual infection with direct invasion of the nail plate. The second (and most controversial) variety is primary distal and lateral onycholysis. In some instances, Candida may only be a "contaminant" with the onycholysis secondary to psoriasis or trauma. However, Hay et al found "primary Candida

onycholysis" to respond to oral azole therapy in patients with peripheral vascular disease, Raynaud's and Cushing's syndrome,[13] suggesting that in these patients, onycholysis was caused by Candida. Nail biopsy showing yeast and mycelium in the nail plate together with distal nail plate erosion correlated with response to therapy and was the best clinical indication of infection rather than "contamination." The third variety described in Saudi Arabia is also reported which is indistinguishable from distal subungual onychomycosis.[12]

I propose strict criteria to establish the role of Candida as a nail pathogen: 1) clinical observations including onycholysis, erosion or thickening of the nail plate or nail bed with no other known cause; 2) positive microscopy revealing pseudohyphae and/or hyphae; and 3) culture of Candida and no dermatophyte fungi or other pathogens. All three criteria should be present to suggest that Candida is causative.

Joint Conclusion

Our knowledge of superficial fungi is rapidly evolving due to double blind studies and newer oral antifungals. The answer as to whether Candida is a primary nail pathogen in the non-immunocompromised host is still unclear. We feel that Candida plays a role in the diathesis of certain cases of onychomycosis. However, there is not enough evidence to date to prove that Candida is a primary pathogen in the non immunocompromised host.

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AMA and USP Seek Physician Assistance in Preventing Medication Errors

The United States Pharmacopeia (USP) offers this information to provide practitioners a beffer picture of the nature and extent of medication errors and to offer specific suggestions as to how physicians, in their day-to-day practice, can help avoid errors.

While the goal of drug therapy is to achieve a therapeutic outcome that will improve a patient's quality of life, there are in herent risks associated with that therapy. Among those risks are medication errors that occur anywhere along the continuum as drugs are prescribed and administered. Errors are preventable when there is increased practitioner awareness of the types and of the knowledge and performance defecits that contribute to them. At its June meeting, the American Medical Association's House of Delegates adopted the following resolution supporting the physician's role in the prevention of medication errors.

BE IT RESOLVED, that the American Medical Association House of Delegates reaffirm its current position regarding drug errors and encourage physicians and their collective groups to initiate local programs to quantify the extent of the drug error problem by, for example, establishing hospital or other local drug error reporting systems via quality assurance mechanisms, and by forwarding appropriate data to existing programs aimed at reducing the incidence of drug errors, including the Medication Errors Reporting Program of the United States Pharmacopeia, and the MedWatch program of the FDA.

Medical therapy results in unintended injuries that have been estimated to affect 1.3 million people each year in the United States.[1] As many as one out of every five doses of medication administered may be given either to the wrong patient, in the wrong dose, by the wrong route, at the wrong time, or even as the wrong drug. Additional studies suggest that in hospitals the prevalence of medication errors is one error per patient per day.[2]

The USP Medication Errors Reporting (MER)

Program has received more than 2,000 confidential reports on actual and potential medication error occurring from the point of prescribing through the administration of the medication. In addition to the anguish medication errors impose on patient and health care providers, the consequences are extremely costly to the health care system. A study by the Physicians Insurers Association of America found medication errors to be a frequent cause for malpractice litigation. In 90,000 malpractice claims over a seven year period, medication error were the second most prevalent and most expensive source of claims. The average indemnity payment for the 393 most recent medication error claims was $120,722 with a range of $5,000 to $2.2 million per claim.

The most common categories of errors reported to the MER program are similar product names (both brand and generic), misinterpretation of abbreviations, similar labeling and packaging, and miscalculations. USP has recently published a *USP Quality Review* with more than 220 reportedly similar product name pairs

Similarities involve trade names, generic names, foreign drug names, and OTC product names. It is not surprising that errors occur when medication orders are incomplete; when verbal and written communication is unclear; or when physicians, nurses, pharmacists, and patients are unfamiliar with drug names. It is easy to see the potential for serious, even fatal, outcomes when drugs are mistaken for each other. The likelihood of mix-ups increases if the drugs are available in the same strength or used in the same dosing interval.

According to the American Medical Association, prescribing errors, which can be subdivided into technical and clinical judgement errors, are caused primarily by physicians. Errors are often characterized by illegible handwriting, misspellings and the use of inappropriate abbreviations in written orders, and garbled or unclear oral orders. One specific area that consistently results in medication errors is the use of abbreviations in prescription writing, as shown in the following examples:

· "U" commonly used to indicate"unit," is misread as a zero resulting in a ten-fold overdose for critical drugs such as insulin and heparin.

· Not all computer systems use abbreviations consistently or exclusively. One example is "AZT," which has been programmed for both azathioprine and zidovudine.

· "PRN" (as needed) and "UD" (as directed) have been found to be consistently associated with errors in medication dispensing and/or administration because these vague dosing instructions provide no assistance for the nurse or pharmacist who may misread the drug name. In 1994, the AMA Board of Trustees recommended the following:

· Written drug or prescription orders should be legible.

· Physicians with poor handwriting should print or type medication orders if direct order entry capabilities for computerized systems are unavailable.

· Medication orders should be clearand complete and should include patient name, drug name, route and site of administration, dosage form (if applicable), dose, strength, quantity, frequency of administration, desired therapeutic outcome, and prescriber's name.

· Physicians should review all drug orders for accuracy and legibility immediately after having prescribed them. Medication orders should be clear and unambiguous.

· Physicians should write out instructions rather than use nonstandard or ambiguous abbreviations (write "daily" rather than "qd," which could be misinterpreted as "qid").

· Avoid vague instructions such as "take as directed."

· To avoid ten-fold overdoses, always use a leading "O" to precede a decimal expression of less than one (e.g., 0.5 ml), but never use a trailing "O" (e.g., 5.0 ml).

· Avoid the use of decimals when possible (e.g., prescribe 500 mg instead of 0.5g).

· Use the metric system of measurement rather than the apothecary system.

· Prescribe by standard nomenclature, using United States Adopted Names, and avoid locally coined names.

General advice for preventing medication errors includes the following:

· Spell names aloud when telephoning prescriptions.

· Use type or block printing for prescriptions (prepared blanks and computer-generated prescriptions work well).

· Always specify drug strength.

· Patient and caregiver counseling is also an additional safeguard against errors. Patients and those who care for them must know, at a minimum, what the medication is for, how it should look, and its name.

To report an actual or potential error, contact USP's Medication Errors Reporting Program at 1-800-233-7767. Each report is shared with the Food and Drug Administration, the product manufacturer, and the Institute for Safe Medication Practices. All reports are confidential and practitioners may choose to remain anonymous. Practitioners receive all follow-up information received by USP and reports are used to stimulate changes in USP drug product standards and drug information.

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AMA and USP Partner to Establish National Drug and Therapeutic Database

The American Medical Association (AMA) and the United States Pharmacopeia (USP) today jointly announced the establishment of a strategic alliance to improve the use of medicines by health care professionals and patients. The two organizations will work together to create a national drug and therapeutic database through the merger of the AMA DE® (drug evaluation) and USP Drug Information (DI) databases. The combined AME DE-USP DI database will provide practitioners information about drug and disease treatment as well as comparisons among various therapies.

"We are enthusiastic about this alliance that will combine two complementary and world class information resources into one premier database," noted AMA Executive Vice President James S. Todd, M.D., in announcing the partnership. "Physicians should know that AMA will continue to maintain the same strong support for the new merged database as an extension of the high quality and clinically relevant drug information that has served practitioners since its inception of the AMA DE® over 20 years ago."

"The prospect of contributing to a more seamless use of drug and therapeutic information is exciting," remarked USP Executive Director Jerome A. Halperin. "By bringing together 322 years of combined experience (USP's 175 and AMA's 147), we are uniting two of the oldest institutions in the United States in serving the public health.

"Together we will continue to provide the nation with a consistent source of information for physicians, pharmacists, and other health care practitioners in private, institutional, managed care, and ambulatory settings and will enhance its means of delivery for all users," said Mr. Halperin.

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AMA Survey- American's Know Little or Nothing About Health Care Advance Directives

More than two-thirds of Americans do not have "living wills," although almost three-fourths say the document is important, according to a report released today by the American Medical Association (AMA).

The report, which details results of a survey conducted by the AMA, reveals that the nation is wholly unfamiliar with health care advance directives, despite education campaigns and federal laws calling for their use. An advance directive is a document in which you give instructions about your health care if, in the future, you cannot speak for yourself.

In response to the report, the AMA, the American Association of Retired Persons (AARP), and the American Bar Association (ABA) today released, *"Shape Your Health Care Future with Health Care Advance Directives,"* a patient guide that combines a living will and health care power of attorney into a single, comprehensive document.

According to the report, the pressure on the patient's family to make health care choices can be overwhelming in cases where there has been no prior conversation about the patient's wishes. "Family members suffer great angst over determining what their ill family member would have wanted. Decisions can be tempered by a fear of personal loss if the sick person dies or a sense of relief if the stress of caring for the sick person has been overbearing," states the report.

"Each American adult must protect themselves and take the necessary precautions so they are in control of their health care decisions," said P. John Seward, M.D., chair, AMA Board of Trustees. "The advance directive form we've created can be used nationwide. It'll give patients and their families peace of mind and can help relieve family stress."

According to the report, the opportunity to express wishes about end-of-life care is a significant means of alleviating public anxieties surrounding death in the modern age Technological advance has resulted in prolonged life, but the care may be of marginal value, depending on the patient's assessment of their quality of life. Completing an advance directive can give individuals confidence that they will maintain control about their end-of-life treatment and will be provided care commensurate with their wishes.

"Preparing an advance directive now is a way to make sure your voice is heard if you should become unable to make your own decisions about medical care," said AARP Board Member Marie Sonderman, R.N. "It's a wise investment for yourself and one of the most valuable gifts you can give to those close to you."

The advance directive form found in the AMA, ABA, AARP booklet is designed to be portable, meeting most state law requirements. In the few states with unusual enforcement requirements, health care providers still must follow the principle of adhering to a patient's wishes. The three organizations are urging all states to recognize a national model, such as the advance directive form found in the booklet.

"The joint authorship of this booklet by the ABA, AMA and the AARP should eliminate confusion about what the law on advance directives is and how to handle issues surrounding terminal illness," said Roberta Cooper Ramo, president, ABA.

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America's Failure to Use Advance Directives- Helping Your Patients Shape Their Health Care Future

Tragically, in 1983, a 25-year-old woman named Nancy Cruzan lost control of her car in Jasper County, Missouri. Cruzan never regained consciousness. For seven years her life was sustained by artificial nutrition and hydration, despite her family's wishes that such treatment be discontinued. She lay in a state hospital while, in 1990, the U.S. Supreme Court deliberated whether Missouri constitutionally could require "clear and convincing evidence of the incompetent's wishes to the withdrawal of life-sustaining treatment.[1] The Missouri Supreme Court concluded that the evidence of record did not meet that standard, despite testimony from her roommate that she would not want to live if she faced life as a "vegetable." It was only after two former co-workers came forward to substantiate this account of Cruzan's wishes that the state courts agreed to grant the family's request. Cruzan died December 26, 1990.

This case rallied patient interest in a systematic way of making wishes known so as to avoid the lingering stagnation Cruzan suffered. The Society for the Right to Die (now Choice in Dying) logged 300,000 requests for advance directive forms in the month following the Supreme Court ruling.[2] It was clear to the public that entrusting decision making power to family members might not be enough to ensure a patient's preferred course of treatment in the face of state law or a health care team's opposition. These events launched attention surrounding advance directives.

What is an Advance Directive?

An advance directive is essentially a fusion of two other health care decision making documents, durable power of attorney for health care and living wills. The former involves the appointment of a proxy to make health care decisions for you if you are unable to do so. The latter is an opportunity to identify specific treatment regimens that you would or would not prefer in various clinical situations. A combination of these two in the form of an advance directive is the most comprehensive guidance one can offer in planning end-of-life care, allowing for both a statement of wishes and an appointed person to ensure the execution of these wishes. This document is designed to be considered, discussed and completed in advance of a crisis situation or a bout of ill health. By contrast, do-not-attempt-resuscitation (DNAR) orders are usually considered while a patient is undergoing acute care. In addition, while DNAR orders only address resuscitation efforts if the heart stops, advance directives can incorporate discussion of a broad range of scenarios and treatments. Advance directives can be revised or

revoked at any time.

Why do I need an Advance Directive?

Inereasingly, patients face a wide range of life-sustaining treatment options. The primary objeetive of advance direetives is seeuring patient autonomy regarding vital health eare decisions in a rapidly evolving medical serviee environment. Unfortunately, there are instanees of undertreatment when the patient would have wanted aggressive measures and overtreatment when the patient would refuse therapy. But decisions regarding aeute eare need to be made by someone and onee the patient's preferenees, values or instruetions are known, deeisions ean be balaneed by input from an appointed proxy, family members and a health eare team's clinieal expertise. The Ameriean Hospital Assoeiation reported in 1990 that in an estimated 70 pereent of all hospital deaths the concerned parties negotiated an agreement to either not start or stop life-sustaining treatment.[2] However, this figure does not indicate that the patients themselves were involved in all of these deeisions, or, if they were not, whether the relatives or physieians had any indieation of what the patient would want. Alternatively, if there is no identifiable family member or surrogate, or if one is not available in an emergeney, a physician who may or may not be familiar with the patient's value system may make the deeision pereeived to be in that patient's best interest. The exeeution of an advaneed direetive would allow for the eventuality that a patient may be too impaired to partieipate in decision making at the time of crisis.

It is erueial to emphasize that advance direetives are designed not only to prevent implementation of heroic measures in end-of-life care, but ean document a patient's wish to have maximum effort made to maintain life, ineluding administration of various teehnologies ineluding ventilators, nutrition and hydration. Wishes for both aggressive treatment and refusal of exeessive treatment can be made explieit in advance direetives. In addition, advaneed direetives are helpful in reinforeing treatment refusal deeisions made by a eompetent patient since health care providers may contend that such wishes are clouded by depression. They can even be a valuable reference for a competent patient struggling with future treatment decisions and trying to elarify values surrounding quality of life.

Despite widely publicized cases like Cruzan, Quinlan and Wanglie, the eourts are generally not the arbiters of end-of-life deeisions when there is no formally expressed intent by the patient. In the vast majority of eases deeisions fall to family members. In sueh cases, especially when there has been no prior conversation about the patient's wishes, there is tremendous pressure on relatives. Family members often suffer great anxiety over determining what their ill family member would have wanted in forming substituted judgment. Decisions can be tempered by a fear of personal loss if the sick person dies or a sense of relief if the stress of earing for the siek person has been overbearing. In addition, family conflict can arise when a decision about life-sustaining treatment needs to be made and the patient, now incompetent, has not artieulated a plan of action. An advanee direetive ean mitigate and eliminate these clashes. In essence, an advanee directive is a legal doeument designed to alleviate the burden of these most eomplex deeisions and ean be a gift to the family members at an emotionally trying time.

Public Sentiments About End-of-Life Care

The opportunity to express wishes about end-of-life care is a signifieant means of allaying publie anxieties surrounding death in the modern age. Teehnologieal advanee has resulted in prolonged life, but the treatments may be of marginal value, depending upon the patients' assessment of their quality of life. The perception that patients may not be provided care eommensurate with their wishes fuels euthanasia and physieian-assisted suicide proponents who are understandably desperate for autonomy and relief. Enaeting an advance direetive provides individuals confidenee that they will maintain control about their end-of-life treatment.

People have strong individual views about end-of-life eare. A 1991 survey showed that 84 percent of those polled did not want eontinued life support if there was no hope of reeovery.[3] However, the number of individuals who have put sueh wishes in writing is relatively small. Despite inereased awareness of advanced direetives and other health care issues in the last five years, the number of people who have eompleted some form of advance directive has not altered substantially. A new poll done for the Ameriean Medical Assoeiation found that nearly one-third of Americans have living wills (32 percent).[4] This is an inerease over a 1990 Gallup Poll found that only 20 percent of adult Amerieans have a "living will."[5] However, both polls illustrate the disparity between those who deem such statement of wishes important and the portion who have aetually followed through on exeeuting a legal document. In the Gallup poll, 75

percent of those surveyed expressed a desire to have a living will in the future and in the AMA survey 74 percent of respondents said it was important to them to have an advance directive.

Barriers to Implementation of Advance Directives

Several barriers to execution and administration of advance directives have been identified in recent years. There is a lacking awareness about advance directives and institutional coordination of directives. Variable terminology such as "living wills" and "power of attorney" may have blurred public understanding of the comprehensiveness of advance directives. In November 1990, Congress passed the Patient Self-Determination Act (PSDA),[6] which required all hospitals which receive federal funding in the form of Medicare and Medicaid to register information about the existence advance directives in admission of all adult inpatients and to provide information about completing advance directives. While a recent report from the General Accounting Office (GAO) indicated that institutional compliance with this mandate had been good, it is unclear that delivery of this information, in practice, is effective.[7] To meet institutional requirements, inquiry about living wills is often part of the laundry list of items completed for admission to the hospital. Written materials explaining advance directives are usually circulated with a mass of other inpatient information. Assigning discussion of such a sensitive subject to busy administrative staff, such as admitting clerks, is not the most effective way to educate about and counsel potential completion of an advanced directive. In addition, at the time of hospital admission individuals are generally unprepared to deal with this personal topic and its discussion may foster unnecessary anxiety and fear. In this sense, administration of the act has not met with expectations. Still, one survey found that after hospital staff informed patients of their right to have an advance directive, 21 percent said they would consider getting one.[8]

While the perception is that many people put off completing advance directives or any death related documentation because they do not want to consider this reality, in fact many patients are willing to discuss end-of-life treatment when the topic is raised.[9,10] Discussion prompted by the physician is probably the most effective means of introducing this idea of advance planning so that personal reflection and discourse within the patient's family can begin. While it makes particular sense to conduct these discussions with older patients, the incidence of accidents among young people points to the additional need for discussion among adults of all ages. A recent survey suggests that physicians may not be comfortable initiating discussion of advance directives, citing uncertainty about appropriate candidates for discussion and a lack of knowledge about how to formulate advance directives.[10,11] Physicians need to be educated about conducting discussions with patients and the procedure for completing an advance directive.[12]

The completion of an advance directive alone is not sufficient for implementation of the patient's wishes. Many people who have advance directives drafted them on their own initiative and may not have even consulted a physician in determining future treatment wishes. This can be problematic both in the technicalities involved in care omission and in the physician's not knowing of the advance directive's existence. Even when someone is sick and being treated in a hospital, their advance directive may not be in place for consultation. One hospital investigation found that even among the minority of inpatients who do have advance directives, only 60 percent have copies of the directive in their medical chart.[8]

A recent study documented that physicians do not always act on advance directives.[13] But rather than an intentional evasion, this is often a factor of the document's unavailability, leaving the doctor with no indication of expressed wishes. This is particularly tragic since when physicians have access to advance directives, they are usually recognized. Investigators found that when an advance directive was recognized, it appeared to influence treatment decisions in 86 percent of cases. Often, advance directives are not forwarded when patients are transferred from long-term care facilities, like nursing homes, to hospital emergency rooms. In the trauma care setting patients may not be lucid and advance directive inquiries are rarely made. Other potential problems in utilization include documents which, as drafted, may not provide useful guidelines or proxies who fail to fulfill their role as decision makers. It may be necessary to institute mechanisms for regular documentation of advance directive wishes in medical charts during an inpatient stay. Forwarding a copy of these completed documents to the physician is an essential component of advance directive completion.

Legislation and End-of-Life Planning

Since passage of the PSDA many states have enacted legislation presenting model advance treatment documents. As of March 1995, 46 states had enacted

laws providing for advance directives incorporating both living wills and health care agent appointments.[7] Of the other five states, three make provision for health care proxies and two have approved living wills. There has been some concern that advance directives executed in one state might not be transferable to another state, mainly because the requirements for certifying advance directives vary from state to state. The AMA-ABA-AARP model found in *Shape Your Health Care Future with Health Care Advance Directives* is designed to be portable, meeting most state law requirements for execution. All states should immediately recognize this document as legally binding and it should be valid in any clinical situation. In the few states with additional or peculiar execution requirements, health care providers are still bound by the principle of listening to patients' wishes. It is hoped that the AMA-ABA-AARP document will set a precedent for national acceptance of flexible, universal advance directive forms.

There are several policy proposals to encourage advance directives. U.S. Representative Ron Wyden (D-Oregon) has put considerable pressure on the Secretary of Health and Human Services to make a model document available. Indeed, the PSDA mandated the Health Care Financing Administration (HCFA) to circulate information about advance directives to all Social Security recipients. This charge is the only provision of the act that has been wholly unmet, reportedly due to budget constraints.[7] The AMA admonishes HCFA to meet this requirement. In addition, the AMA has called on HCFA to circulate advance directive information and model forms to all Medicare recipients upon enrollment. This is in keeping with the AMA's commitment to promote advance directives, identifying them as a potential patient responsibility and "the best insurance for individuals that their interests will be promoted in the event that they become incompetent."[14] To make sure the advance directive is incorporated into treatment, some have suggested that physicians be trained in advance directive counseling, serve as required cosigners on the document and receive reimbursement for these services.[12] It may also be appropriate for the



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legal profession to incorporate knowledge of advance directive into the Multistate Professional Responsibility Exam (MPRE) or sections of the Bar exam. Finally, there is a movement to have a national, state or local registry for advance directives.

Much of the advocacy surrounding endstage treatment invokes cost-savings as a rationale for advance planning. However, evidence regarding the potential cost-savings from implementation of advance directives is inconclusive. It is estimated that reductions in life-sustaining interventions at the end of life would have savings, but no more than 3.3 percent of the total national health care expenditure.[15] And it is far from clear that advance directives would play a major role in forcing withdrawal of life-sustaining treatment that would not have been done anyway. More importantly, advance directives might relieve surrogate decision makers' preoccupation with the financial burdens of end of life care.

Societal Benefits of Advance Directives

Public concern about controlling decisions near the end of life should be allayed by advance directive initiatives. Patients should capitalize on this opportunity to empower themselves and their loved ones with advance directives designed to provide control, set limits, and indicate desire for comfort. While these issues may be most prominent for senior populations, people of all ages should take this model advance directive and ponder decisions of treatment alternatives and proxy appointments with the same weight most Americans give to assignment of assets. As wills and living trusts are established by individuals to secure the economic future of the family, an advance directive is the modern legal tool to ensure emotional relief to families and oneself in critical health care decisions

The force and importance of advance directives is increasingly recognized. Mechanisms to increase access to advance directives are in place. Advance directives are an occasion for physicians to learn about their patient's treatment values long in advance of a critical situation. For patients, they are a chance to provoke discussion within families and make provisions so that the burden on loved ones at trying times is lessened. Finally, advance directives are a unique opportunity for individuals to lend their voice to the most intimate decisions on life and death, in the event that they are unable to do so.

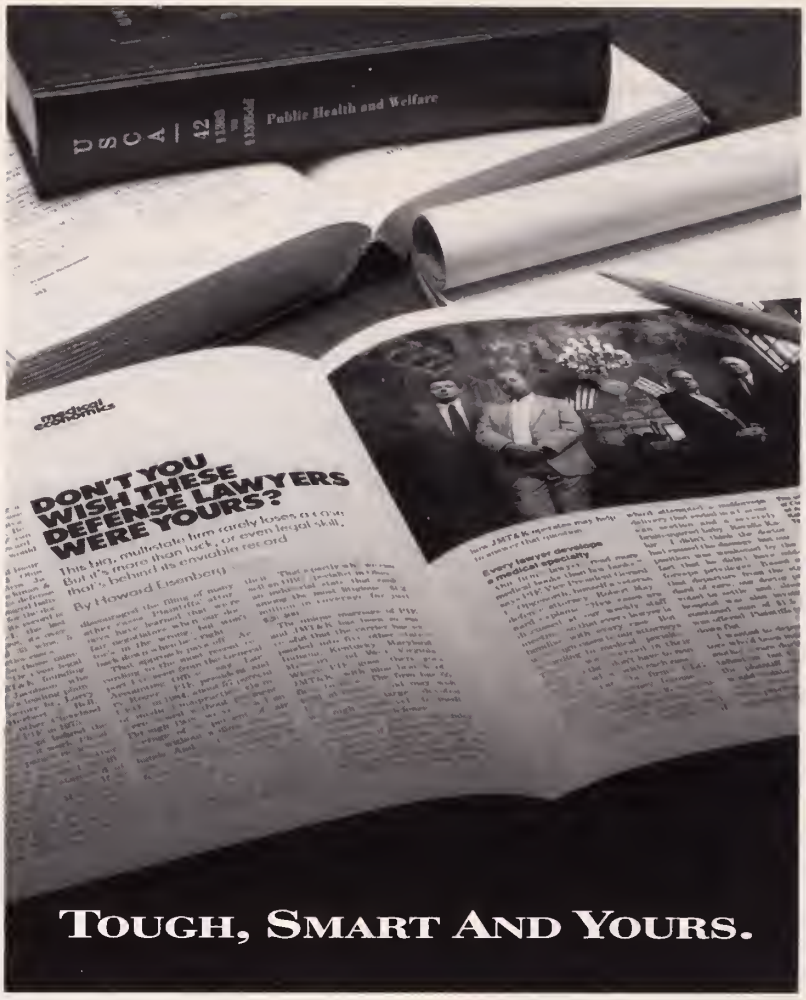
Editors Note: *This article is meant to assist you with patient education on advance directives.*

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Physicians' Recognition Award

Twelve MSMA members were named recipients of the AMA Physicians Recognition Award in August, September and October 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
Emily Rene Baillio, MD
Craig Addison Cole, MD
George C. Hamilton, MD
Joseph Howard Robinson, MD
Mary Lane B. Wheatley, MD

Coust Counties Medical Society
Leland Ray Kendrick, MD
Barbara Nell Massony, MD

Northeast Mississippi Medical Society
Robert Franklin Cooper, MD
Thomas Senter Glasgow, MD

Prairie Medical Society
Steven C. Brandon, MD

Singing River Medical Society
Paul Harold Moore, MD

West Mississippi Medical Society
Sandra Falgout Burford, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**



D. Stanley Hartness, Jr., MD

The President's Page

Rx for Legislative Success

Calvin, the ever-pragmatic philosopher, is engaged in building a snowman with his long-suffering sidekick Hobbes. After only a few minutes he laments, "I'm bored... Let's go in...This is taking too long...It's kind of cold and the sun's too bright and my gloves are getting wet...And when you think about it, building a snowman is a lot of work...I didn't come our here to do something hard."

Calvin then decides to retreat indoors, pull down the shades, and watch television in complete physical comfort- with the remote control, of course. But as he trudges toward his house, he mutters, "I can't believe the only way to get inside is by WALKING!"

This cartoon scenario reminds us that with the '95 campaigns and elections now history, we are faced with the reality of the '96 legislative session. Many associations act as if the legislature is a magical kingdom where special unwritten rules apply.

Just the opposite is true. MSMA's legislative agenda will focus on a fair statute of limitations and establishment and funding of a single state health care policy and planning agency whose first task would be to design a comprehensive revision of state Medicaid program under a block grant funding mechanism. The success of these efforts will depend on the active participation of our members at the grassroots level. The feelings of constituents weigh heavily in the legislators' decision-making process, but they can't read minds. The squeakiest wheels do indeed get heard.

Any legislative agenda is a dynamic work in progress. The timely "Blue Sheet" will serve to keep us posted as the session unfolds and to raise our awareness of the pressures faced by our Council on Legislation chaired by John Lucas of Greenwood under the keen eye of MSMA Lobbyist Charmain Thompson.

We cannot rest on our laurels. Political action and grassroots activities are essential elements of getting our message to legislators on issues affecting our profession and our patients. The Health Issues Forum scheduled for January 16 at the Ramada Coliseum will provide a unique setting for MSMA members to become better informed about the legislative process on both the local and national scenes.

"The key to legislative success is nothing complicated," says Alfred Gilchrist, legislative director for the Texas Medical Association. "Like any long-range plan it includes setting goals, allocating resources, and outlining an action plan." Our legislative council and staff can provide the framework and act as facilitators, but a truly successful '96 legislative program will depend on the tireless vigilance and prompt response of MSMA members.

Although the wind may be bitter cold, the sun painfully bright, and our gloves uncomfortably wet, we will feel a sense of accomplishment when we've finished that snowman.

Stanley

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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVI, NUMBER 11
DECEMBER 1995

Second Opinion and More Sought for Description of Managed Care

Dr. Powell lived way up Waban Hill, where the really big houses were, and when I was a kid, I used to walk up there for my checkups.

He was my family doctor. He knew my name, he'd ask about my parents and he didn't mind spending time with a patient—not when he took the time to reassure an overimaginative 12 year-old that the white and sickly skin around a cut wasn't gangrene and that band-aids need to be changed from time to time. 'I know I should have asked my folks first before dropping by, but Dr. Powell didn't mind. He didn't bill us for that, either

I was thinking about Dr. Powell, who retired years ago, because of a letter I got the other day from a public relations person at a local health insurance company.

Objected to Newspaper Description

The insurer objected to a description The Times-Dispatch has been using for "man "managed care," which we've been describing as a kind of health plan that tries to cut costs by controlling when and how people get access to health care.

The PR person proposed, instead that we describe managed care as: "The term used to describe a health-care delivery system that emphasizes prevention and a personal relationship with one physician in order to provide more cost-effective medical care."

Managed care, the spokesperson added, provides easier access to health care and a choice of family physicians. A 1994 survey showed that 83 percent of HMO members were happy with their coverage, compared with 77 percent of people covered by traditional plans. That's a 6 percent point difference.

Doctor Picked From A List

Under my own managed care coverage, my family doctor is a corporation. We picked it because it was on a list the HMO gave us. Same with the managed care coverage my family had when we lived in Tidewater.

The Health Insurance Association of America—the trade association for health insurers—takes a couple of paragraphs to define managed care.

Its definition uses other jargon terms, but when-you look everything up, the key elements the association emphasizes are that a managed plan selects doctors and hospitals for its members to use, steers members to those doctors and hospitals, and tries to reduce unnecessary hospital admissions and control the length of stay for patients.

It doesn't say anything about preventive care or a family doctor relationship.

(Continued on page 400...Managed Care, please see Editor's note seeking your response.)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Editorial

(*Managed Care, continued from page 399*)

Nor does William M. Mercer Inc., a group that advises insurance companies and employers on health plans. Mercer defines managed care as a system that tries to control costs by managing utilization and price.

System Based on Limited Network

The Times-Dispatch definition derives from the fact that every variety of managed care is based on a limited network of doctors and hospitals, a set of rules for how to use them and a role for the insurer in saying what kind of care is or is not appropriate for a particular patient. Under managed care, the person the doctor consults before sending you to a hospital is an insurance company employee.

But not every kind of managed care necessarily involves a family doctor relationship with a single physician. Nor do other ways of paying for health care necessarily rule that relationship out.

The same goes for preventive care.

The goal of managed care plans may very well be satisfied customers who are in better health.

But surely that is the goal of everyone in health care?

David Ress
Finance Columnist
Richmond Times-Dispatch

Editor's Note: JOURNAL MSMA would like to print your description of managed care. From your experiences, how do you feel managed care should be defined? Write us at P. O. Box 5229, Jackson, MS 39296-5229. A future issue of JOURNAL MSMA will print all responses.

Reprinted with permission:
Richmond Times-Dispatch, September 4, 1995; section D, page 21; Media General.

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Editorial

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DECEMBER 1995

The Fourth Epoch

As the Medicare pot boils over on Capitol Hill one searches the newspapers daily for a sense of the way things are headed, of which force, reason or darkness, holds sway. But like the days of the Victnam War one finds only a crumb here, a morsel there, and is left to his own devices to piece them into coherence, perhaps finding that some supposed victory, like the Tet Offensive, was actually the onset of defense.

But some salient points emerge, even now. Nothing, apparently, is proposed to try to curb the public's enormous demand for medical care, a demand that grows each year. The one simple stroke of lifting the price controls, the one deed sure to make someone reflect on whether a doctor's visit is really needed, seems nowhere in the cards. Instead, the twist is to place the doctors in the position of selecting among those clamoring for attention. It figures. What politician wants to make the selections, and wouldn't swim a moat full of crocodiles to avoid it?

The search for the Fountain of Youth is as old as man. "Now what is history?, muses Dr. Zhivago's Uncle Nikolai in the Pasternack novel. "It is the centuries of systematic explorations of the riddle of death, with a view to overcoming death. That's why people discover mathematical infinity and electromagnetic waves, that's why they, write symphonies." One of the modern versions of this search is the idea of free, or nearly free health care. No politician seems willing to get in the way of this force.

We have witnessed three great epochs of the increasing demand for health care. The first began with the establishment of the British National Health Service. The concept of a line forming for surgery became a reality. The second began with the establishment of Medicare-subsidized health care had made it to this shore. The third came in 1980 when CNN's "News From Medicine" began broadcasting the latest studies and devices, the little bit of knowledge, and the now common expression, "Ask your doctor."

With the changes in Medicare the fourth epoch is upon us. The illusions of cheapness and the Fountain of Youth are to be maintained. But as a friend related the other day, "I have a lot of Medicare patients, and they're sick. If I had to take care of them for $15 a patient per month, I'd go broke."

So like the cheap air fares to San Francisco that always seem to have sold out last week-plenty of regular fare seats, if you like-the public is poised to find that yes, the care is cheap, it's just unavailable.

Leslie E. England, MD
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



MSMA President D. Stanley Hartness, MD *addressed the Central Medical Society, October 3, 1995 at Primos Northgate in Jackson.*



MSMA Alliance President Jeanne Morrison, Attorney General Mike Moore, The Honorable Mrs. Kirk Fordice, Kathy Fletcher *and* ***Central Medical Alliance President Lydia Jones*** *kicked off the Stop America's Violence Everywhere (SAVE) campaign. Mrs. Fordice proclaimed October 11 annual SAVE Day in Mississippi.*



MSMA Alliance President Jeanne Morrison *and* ***MSMA President-Elect Fred L. McMillan*** *addressed reporters at a SAVE press conference held at the Capitol.*

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Delbert Hosemann, Jr.**, attorney for the Jackson Medical Mall Foundation, leads the press conference at the Jackson Mall which announced plans for the foundation to lease the mall for health care services. Behind Hosemann are, from left, Jackson mayor **Kane Ditto**, Tougaloo College president **Joe Lee**, UMC vice chancellor **Dr. A. Wallace Conerly**, University Hospitals and Clinics director **Ted Woodrell, Dr. Aaron Shirley**, director of Jackson Hinds Comprehensive Health Center, and Jackson State University president **Dr. James Lyons.

Medical Mall Deal Closed

The Jackson Mall became the property of the Jackson Medical Mall Foundation today, and a major share of the outpatient services of University Hospitals and Clinics (UHC) will be housed there.

Vice Chancellor Dr. A. Wallace Conerly says the space will be ready for occupancy "no later than January, 1997." The owners of the mall sold the property to the foundation for $2.7 million, and the Medical Center will lease clinic space from the foundation.

The Board of Trustees, Institutions of Higher Learning approved the proposal to lease the mall at its September meeting.

The foundation board of directors includes president Dr. Aaron Shirley, director of the Jackson-Hinds Comprehensive Health Center, Rueben Anderson, Jackson attorney and former Mississippi Supreme Court judge, Dr. James Lyons, president of Jackson State University and UHC director Ted Woodrell.

Jackson and Hinds County officials have agreed to resurface the 5400-space parking lot and provide a security fence and landscaping.

The first tenants will be UHC clinics, the Jackson-Hinds Comprehensive Health Center, and Mississippi Blood Services. "Because the foundation is nonprofit, 95 percent of all tenants must be nonprofit organizations," Dr. Conerly said.

Future tenants could be the City of Jackson's Division of Human Services and the Hinds County Health Department.

The mall will provide approximately 800,000 square feet of rentable space. The Medical Center will lease 165,000 square feet in the three-story building which was once the Gayfer's store for "all our clinics not dependent on special equipment or laboratory facilities," Dr. Conerly said. For patients who need to be transferred to the main campus for other diagnostic services or treatment, and for students, staff and faculty, a shuttle bus will make continuous runs to the Medical Center all day long. According to Dr. Conerly, the entire structure is in excellent repair with a roof only three years old.

Included in the Medical Center's long-range plan for leasing other space in the mall are the possibility of day care centers for both adults and children, space for clinical research, and conversion of the movie theatre into an educational center.

As for impact on the UMC campus, the move will greatly alleviate congestion at the front of the hospital. "We're talking about at least 100,000 patients in a year in addition to the people our patients bring with them." Plans were already underway for renovating the front of the hospital, he said.

The space left when the clinics move won't have any shortage of takers. "The need for clinical space throughout the center is so critical, we'll put it to good use," Dr. Conerly said.

Dr. Conerly notes that an ambulatory care center has been in the Medical Center's long range plan for many years. A consultant estimated that new construction of 165,000 square feet for such a center would cost at least $30 million. The same space will be leased at a cost of $1.6 million per year--a cost that includes the necessary renovation and the transformation of space designed for retail sales into usable clinics.

Dr. Conerly says that credit for the concept and eventual implementation goes to Dr. Shirley and Anderson who approached Dr. Conerly and Woodrell with the plan. "That was only six weeks ago, and all the paperwork has been done. It was a window of opportunity for us that we could not ignore," he said. "It was a case of 'do it now, or don't do it.

The 53-acre Jackson Mall opened in 1969, but suffered from a dearth of customers after the Metrocenter Mall opened in 1978 and again in 1985 when Northpark Mall in Ridgeland opened. Once the home of Gayfers, J.C. Penney, and Woolco, the mall's retail stores began moving out, leaving only a few tenants and a lot of vacant store space.

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CASE RECORDS OF THE UNIVERSITY OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE X

Selection and Preparation:
Richard D. Guynes, MD
Roger L. Huey, MD
Michael R. McMullan, MD

Joe C. Files, *Editor*

Differential Diagnosis: James G. Wilson, MD
Radiological Findings: Mary Jean Magruder, MD
Pathological Findings: Turner L. Willis, MD

CASE PRESENTATION

A 45 year old black male from Indianola, MS, presented to the University Medical Center Emergency Room on February 28, 1994, with a six week history of mid-abdominal pain which was constant and non-radiating. The pain was not influenced by meals, position, or activity. He reported a decreased appetite and a 16 pound weight loss with generalized weakness. He described three loose stools daily without foul smell, melena, or hematochezia, and no nausea, vomiting, fever, cough, headache.

He was initially evaluated at his local hospital in January, 1994. Those records revealed the following lab values: WBC of 18,600 with 85% segs and a hematocrit of 28.4%. A UGI showed chronic gastritis, deformed duodenal bulb. Chest x-ray showed apical blebs and left hilar calcified granulomas. An ultrasound of his liver, pancreas, and gallbladder were all within normal limits. A HIDA scan was negative. A CT of the abdomen revealed fatty liver, mild biliary duct dilation, and a large retroperitoneal mass.

He was transferred to a regional hospital where further evaluation revealed: hepatitis serology - + HBs AG, + HBs Ab. A repeat CT showed colonic dilation, no mass or adenopathy. An ultrasound of the abdomen was within normal limits. A small bowel series was within normal limits. An EGD with biopsies showed acute and chronic gastritis and duodenitis.

The patient was discharged on Spironolactone, Lasix, Cimetidine, and Amantadine. His diarrhea eventually resolved. Abdominal pain, anorexia and weight loss progressed and he presented to the University Medical Center Emergency Room requesting further evaluation.

His past medical history was significant for peptic ulcer disease with perforation and repair that required blood transfusion in 1980. His medications included Amantadine, Spironolactone, Lasix, and Tagamet.

His social history revealed that he smoked 1 ppd but quit one month prior to admission. His ETOH history was 2-3 pints whiskey/weekend but he had quit in October, 1993, and used no drugs. He had had the same girlfriend for 4 years and had unprotected sex, but no homosexual activity.

His examination on presentation to the University Medical Center showed his temperature was 98.4 , his pulse was 105, his blood pressure was 152/97, and his respiratory rate was 20. He was a cachetic black male in mild distress secondary to abdominal pain. His abdomen was flat with normal bowel sounds and was diffusely tender especially in the periumbilical region. There was no rebound or guarding. There were no palpable masses or HSM and no fluid wave. Stool was brown and heme negative. His extremities showed moderate atrophy of the muscles, especially the lower extremities, but no edema. The remainder of the physical exam was within normal limits.

Laboratory obtained at the time of admission was pertinent for a WBC of 13.9 with 75% segs, 16 lymphs, 6 monos, 2 eos, and 1 baso. Other lab showed a hemoglobin of 10.5, a hematocrit of 32.6, and platelets of 524,000. His MCV was 90, an RDW was 16.3, and an ESR was 111. His Na was 134, Cl was 92, K was 3.7, and HC03 was 31. His albumin was 2.7 with an alkaline phosphatase of 194, a total bili of 0.8, a PT of 12.3, and a PTT of 28.1. His Bun was 11, Cr was 0.6, TP was 6.2, GGT was 122, ALT was 41, AST was 44, Amylase was 46, LDH was 758, and Glu was 106. His urinalysis had 2 white cells, 3 red cells, and a few bacteria. A chest x-ray showed a calcified granuloma in the left hilum.

He was admitted on March 1, 1994, to General Medicine. Diuretics were discontinued and IV fluids begun. The evaluation included a PDP with control that was negative, a CT of the abdomen that showed increased mass effect in the stomach wall, duodenum and jejunum, small defects in liver up to 5mm in size, and a gall bladder wall that was thickened. He had a left para-aortic adenopathy noted but no mass was seen. A hepatitis serology showed HBs AG, HBc Ab, HBe Ag, negative HC Ab. He was HIV negative. His upper endoscopy was repeated on March 4th and superficial erosions were noted in his stomach. A liver biopsy was done on March

8th with no evidence of inflammation or granulomas.

The Digestive Diseases and Infectious Diseases services were consulted. Abdominal pain was controlled with IV narcotics, his appetite improved, and the patient remained afebrile.

An ERCP on March 11, 1994, was negative except for areas of mucosal erosion noted in the small bowel. Later that day the patient began to complain of pain in his abdomen, left hamstring, and knee. His exam was unchanged from admission. At 11:00 p.m., he complained of gradual onset SOB and "numbness" in his LLE. He denied leg pain, chest pain, or cough. Exam revealed a blood pressure of 140/102, pulse of 110, respiratory rate of 22, bilateral rales, tachycardia with S3 gallop, pulses 1+ and equal, and no edema.

His arterial blood gas at that time showed a pH of 7.42, a PO_2 of 55, and a CO_2 of 37. An EKG showed sinus tachycardia at a rate of 119 with left ventricular hypertrophy, and nonspecific ST-T changes. A chest x-ray showed diffuse bilateral, interstitial infiltrates.

He was treated with IV Lasix, Morphine, and supplemental O_2 with improvement. At 0600 the patient was found by the nurse without vital signs. Code Blue was called but resuscitative efforts were unsuccessful.

The diagnosis was made at autopsy.

Dr. Magruder: On his chest x-ray upon admission in the ER, he had calcified lymph nodes in the left hilar region but otherwise was essentially unremarkable. His KUB also taken in the ER at that time showed multiple air fluid levels within mildly dilated large bowel. There was small bowel within the pelvis. These changes were consistant with an ileus or early large bowel obstruction. There was mildly dilated transverse colon in the mid-abdomen. His CT scan with oral and IV contrast shows an area of thickening along the stomach wall. Sometimes this is seen if the stomach is non-distended. Small hypodensities were seen scattered throughout the liver. They were no larger than 5mm in size. Above the right kidney there is some duodenal thickening, which was commented upon. The gall bladder wall does appear thickened. To the left of the aorta was an enlarged lymph node. It measured approximately 1-2 centimeters in size. Some free fluid in the abdomen was present in the right hepatorenal space. There was also some small bowel, possibly jejunum, that also appears thickened. A radiograph from his ERCP showed filling of common bile duct with no filling defects identified. The ERCP was essentially unremarkable. His last chest radiograph showed diffuse bilateral interstitial infiltrates, mainly the perihilar regions.

Dr. Willis: During the patient's hospitalization, we were sent several biopsies. We received a duodenal biopsy on March 4th which had no diagnostic alterations. Also, on March 4th, we received a gastric biopsy which exhibited moderate superficial widening of the intraglandular spaces and a mild increase in plasma cells consistent with mild superficial chronic gastritis. Due to the history of peptic ulcer disease, we made an extensive search for helicobacter organisms but none were found. On March 7th, we received a liver biopsy which exhibited mild portal inflammation as well as a few histiocytes and plasma cells. However, these were all very minimal findings making this an almost normal biopsy. No hepatocellular necrosis or signs of hepatitis were seen. In light of the history of hepatitis, immunoperoxidase stains from hepatitis B s antigen were ordered. Only two positive cells were found on the entire biopsy. Lastly, a repeat duodenal biopsy received on March 11th showed mild intraglandular inflammation with a plasma cell infiltrate and rare intraepithelial neutrophils. This was diagnosed as mild duodenitis. Again, these pathological findings were minimal and did not explain the patient's symptoms.

Dr. Wilson: Let me preface my remarks by saying that nothing I say today should be construed as suggesting that I could have made this diagnosis ante mortem. It remains to be seen whether I made it post mortem. I tried to look at ways during the evaluation of this patient that an approach may have led to additional studies that might have made a diagnosis ante mortem. I think that the course of the studies during his life was appropriate. The structural possibilities had just been addressed fully at the time of this terminal event so that additional studies that may have been appropriate were not possible.

This is an individual who had a six week history of abdominal pain and anorexia with some diarrhea. The diarrhea was unimpressive with 2 or 3 bowel movements a day that were somewhat watery for a period with resolution subsequently. The quality of the abdominal pain was not very helpful in making a diagnosis. It was a constant abdominal pain. It was not related to meals, so it did not allow one to build a case for postprandial ischemia. Nevertheless, it could have been consistent with ischemic abdominal pain. It could have been consistent with an expanding lesion in an encapsulated organ like the liver or with invasive disease as in neoplasm. He was truly anorectic. The 16 lb. weight loss by his history was not fully documented, but physical examination showed him to be cachectic. There was muscle wasting and the abdominal exam was not very helpful except in what it did not show. He had normal bowel sounds. The abdominal exam, unlike what may have been suggested by the x-rays, did not support the idea that he had an ileus. He had no

hepatosplenomegaly. There were no palpable masses. (Was there any history of muscle tenderness? - No. - That may have given an additional organ system to investigate.) He had a hematocrit that was, on various determinations, 28-32. His white count was invariably high at 14,000-19,000 and it was neutrophilic. Remarkably, there were very few eosinophils. His platelet count is very helpful. The platelet count would tell you what you need to know without even having the sed rate. A platelet count is as good as a sed rate in helping you know that there is systemic inflammation. This is a picture of a patient who had an ongoing inflammatory process that was quite substantial as reflected by his anemia, by his markedly elevated sed rate, and by his elevated platelet count. With respect to his anemia, his stool was heme negative. He had a slightly increased RDW, but not to a range that might be expected if he had active hemolysis. There was nothing about his anemia to suggest an active hemolysis. It appears to be the anemia of subacute disease in this case. This is not a patient you are going to send home after his abdominal pain resolves and he is going to do fine and never come back. This is someone in whom a diagnosis is to be made.

There are three categories of illness in which the diagnosis might likely fall. Those are infectious, neoplastic, and inflammatory. I think that of those three, when we see a patient like this, we are least likely to emphasize early on the inflammatory possibilities. I have listed his risk factors for various neoplastic, toxic, or inflammatory problems. He was a smoker; obviously that predisposes him to develop cancer. His alcohol intake could predispose him to develop cirrhosis, but also any chronic inflammatory condition of the liver could predispose to primary hepatic carcinoma. That is a consideration.

He had a transfusion in 1980, which is 15 years ago. That may explain his antigen positivities. It certainly also provides the risk of developing AIDS, and that is a consideration in this case. He had unprotected sex, which is a risk factor for the same things that one could get from blood transfusions. It is interested that he stopped drinking in October, 1993, about 2-3 months before he presented here, and stopped smoking about a month before he came here, as well. When people spontaneously stop smoking and drinking, that tells you that they are sick, too. This is another reason to think that this person had a significant systemic illness which became evident later on.

This summary slide is not taken in the order that you collected the information, but provides a useful order for me to think about the data. His chest x-ray told us he was a smoker from Mississippi who probably had old histoplasmosis. Significantly, there was no apical scarring noted as might have been seen in someone who had primary tuberculosis at an earlier date and who had reactivated it in another organ system. He had two normal abdominal ultrasounds, but on an initial CT there was this report of a large retroperitoneal mass. I think in view of the other data that we have at our disposal, we have to discount that initial report. With CT, particularly in an emaciated person when you don't have the fat planes to help you discern the retroperitoneal space, if you don't opacify the small bowel by intra-alimentary contrast, then small bowel can give the appearance of a retroperitoneal mass. That may be responsible for that initial finding. His upper GI and small bowel series showed chronic gastritis and old peptic ulcer disease. That is also consistent with the biopsies that were obtained here. CT of his abdomen did appear to show some abnormalities, but those abnormalities involved several points along his alimentary tract including his stomach, duodenum, jejunum, and also gall bladder. There was some wall thickening. This is a diffuse process and it makes one think either of a diffusely metastatic carcinoma, which would be unlikely, or perhaps a vascular process because obviously all of these organs have blood vessels. His left para-aortic adenopathy would be consistent either with infectious disease, or neoplastic disease, or inflammatory disease and really does not help much. Those were not immensely impressive nodes, as might be seen in metastatic carcinoma. The liver defects are interesting. I will discuss those at the end before I make my predictions about the autopsy findings. There are diseases in which liver defects like this can occur in the setting of ischemia, and I will be talking about one of those diseases.

His endoscopy studies showed superficial erosions of the stomach, and also during his ERCP, he was noted to have mucosal erosions of the small bowel. These are fairly nonspecific findings. The fact that there were small bowel erosions suggests that whatever may have been causing those erosions was not necessarily hyperacidity because in the small bowel one would not expect erosions from that source. Ischemia could be associated with mucosal erosions. I am getting into the areas of expertise of numerous other people, and if I say something on which you would like to correct me or expand, please feel free to do that.

Let's consider the information having to do with infection. He had no upper lobe scarring in his lungs. His PPD was negative with control. Presumably the control was positive. If someone has a negative PPD and a negative Candida, obviously they could be anergic. There are situations in active pulmonary tuberculosis when someone can have an active Candida skin test, but be anergic specifically to TB because of an antigen excess. That particularly occurs in the setting of a tuberculous

pleural effusion, which was not present in this case. I think that certainly does not support the idea that he had tuberculosis, and it is a good argument against tuberculosis in this patient. Alimentary tuberculosis or gastrointestinal tuberculosis can be very hard to diagnosis. People can die of it and it is a diagnosis that may be made at autopsy. That would be surprising in a person who did not have evidence of earlier primary pulmonary tuberculosis. His HIV is negative and that is helpful. Certainly, HIV is a wasting disease that we see in people who have had transfusions and who have had unprotected sex. This is an important negative. Fever was not noted in the protocol. I assume that it was not a prominent part of this person's course. Had it been prominent, it still would not have helped to decide whether this situation was infectious, neoplastic, or inflammatory. Fevers can be present in any of those causes of this degree of systemic inflammation. Blood cultures are not specifically mentioned in the protocol. It is mentioned that Infectious Diseases was consulted, so I think we can assume at this point that he had multiple blood cultures and I assume that those are negative. It is a little surprising that he has not had fever with this degree of inflammation. You can see this with cancer and people will not have fever. If this had been infectious, it would have been quite surprising. Among infections, besides tuberculosis, you ask yourself whether subacute bacterial endocarditis could have been present here. There is not much to suggest that. No murmur was mentioned. His blood cultures were presumably negative. He did not have any of the peripheral stigmata of septic emboli and so there is not much to point to subacute bacterial endocarditis. He did have a couple of red cells in his urine and a white cell, which likely is a nonspecific finding but may relate to the diagnosis that I will eventually propose.

His hepatitis serology is our first positive and there is a surprising finding that he had both hepatitis B surface antigen positive and hepatitis B surface antibody positivity. This can occur. It is rare. The textbooks say you can have this situation if you have antibody to one subtype and are actively infected with another subtype of Hepatitis B virus. It is also said that perhaps this could occur in a brief window of time when you are switching from antibody negativity to antibody positivity. Because of what we know of antigens and antibodies, they do not coexist well in solution. The antibodies bind their antigen and they are rapidly cleared either by insolubility in peripheral tissues or by the reticuloendothelial system, so that would be surprising.

Here, he was hepatitis B surface antigen positive, core antibody positive, and hepatitis B E antigen positive. The hepatitis B surface antigen relates to particles in the blood stream that on electron microscopy are either 22 nanometer small spherical particles or may have filamentous structures, and this is excess viral coat protein. It can be produced by somebody who is chronically infected without a replicative infection going on. These people may not be replicating intact virus but may be making excess coat protein. However, when hepatitis B E antigen is present, that indicates that there is replicative infection going on and this is the patient whose needle stick you don't want to get. This is the person who is most likely to give you blood born hepatitis B. Finally, he was negative for hepatitis C antibody.

Nothing tells us what was going on in his liver. His enzymes won't tell us. The only way you can know what is going on at a hepatic level is to do a biopsy, which was done. Here are the chemical tests that help us analyze what may have been occurring actively in his liver. His liver enzymes, which are not function tests, but indices of tissue damage, were unimpressive. His AST and ALT were upper level normal. His GGT was also unimpressive. His alkaline phosphatase was up but also not in a very impressive range. His LDH is rather high. I think there is sufficient information to suggest that a portion of this was from his liver. I will suggest later on that some of it may also have been from his heart at various points during his course, probably not on admission here. It may have been from muscle because he had some muscle wasting and in the systemic vascular disease that I will suggest, there certainly is muscular infarction. LDH is present in almost all body tissues, hemopoietic tissues included, but there is nothing much to suggest that this was coming from a hemopoietic source. His albumin was 2.7. In this case, that is more likely to have been nutritional than biosynthetic in origin. His protime and partial thromboplastin time were both normal indicating at least by this crude index of hepatic biosynthetic capability he had good hepatocellular function. Likewise, his total bilirubin, which is an index not only of the liver's capacity to detoxify but also of the biliary drainage system, was normal. The amylase, which gives you some idea of the biliary drainage system and also lets you look crudely at his pancreas, was normal. His liver biopsy showed no inflammation or granulomas. Allowing for the fact that one can have sampling error, that certainly does not support the idea that he has cirrhosis. It does not support the idea that he had chronic active hepatitis as a source of this systemic illness. It is probably worth mentioning that when he was seen at the other hospital, he was placed on Spironolactone and Lasix, suggesting at that point that he had edema of some degree. I don't know why he would be put on those drugs otherwise. The fact that Spironolactone was used suggested that they were attributing his edema to a hepatic source. At that point, because they had evidence

that he had a chronic infection, they were attributing a lot of his clinical picture to liver disease which on subsequent biopsy he did not have.

He has also had an ERCP. He has had multiple CTs. He has had ultrasounds. The structural aspects of his intra-abdominal cavity have been addressed pretty thoroughly looking for cancer which would be your first bet in a patient looking this way. We have come up empty handed in that regard. Likewise, infectious possibilities as an explanation for this picture have been investigated and, once again, we have come up empty handed. That leaves us looking at inflammatory disease. If you are looking at an inflammatory disease that makes someone this sick without obvious stigmata of lupus, without obvious stigmata of rheumatoid arthritis with rheumatoid vasculitis, you really look at the vasculitides. On this slide showing a list of vasculitic syndromes, which is not exhaustive but is fairly complete, one can find good reasons to rule out just about everything except one. Hypersensitivity vasculitis is a small vessel vasculitis and would not have, in most cases, explained his abdominal pain, though Henoch-Schonlein purpura is one of these and is marked by abdominal pain. With Henoch-Schonlein purpura, the patients are not generally this sick, it generally occurs in children, frequently occurs in the springtime, and generally resolves spontaneously. He did not have a rheumatic disease with which to associate a vasculitis. We will skip over polyarteritis nodosa for now, but certainly come back to it. He had no eosinophilia. He had no prominent asthmatic manifestations, arguing against allergic angitis and granulomatosus (Churg-Strauss). He lacked obvious involvement of his upper or lower airways, arguing against Wegener's granulomatosis. Likewise, with lymphomatoid granulomatosis, he also had no significant head and neck pathology. Again, pulmonary involvement was not prominent. Takayasu's and giant cell arteritis are both associated with ischemic problems, but not with this degree of systemic illness and generally are not marked with this sort of abdominal pain. He certainly is not the picture of Kawasaki's or Behcet's. So, let's come back to polyarteritis nodosa. This individual probably had a systemic vasculitis involving small and medium vessels. He probably had polyarteritis nodosa. There is another reason to come back to this disorder in this individual. If you give a rheumatologist a patient with hepatitis B antigen positivity, he will invariably think of polyarteritis nodosa or mixed cryoglobulinemia. To a hammer, the whole world is a nail.

This is not the picture of mixed cryoglobulinemia. This patient probably did have polyarteritis nodosa. We'll look briefly at some of the features of that. This slide is more a guide to what we might expect on autopsy than what you saw clinically because many of these findings may be subclinical. He had minimal evidence that he had any renal involvement, but 70% of patients are found to have renal involvement at autopsy. There is good reason to think that he had cardiac involvement and we will get back to that when we talk about his terminal events. He certainly had GI tract involvement. In his terminal event, we will talk about his peripheral nerves. I think there is good reason to think that he had a mononeuritis multiplex during the last day of his life. He did not have skin involvement and it is unclear whether he had skeletal muscle involvement. CNS involvement occurs in the series that this came from in 10% of the patients, perhaps up to 1/4 in other series. So, in considering a cause of death, we can't leave that out though there is nothing specific to suggest it in this patient. He certainly could have died of a CVA. The next few slides illustrate some of the typical pathologic findings that may be seen in polyarteritis nodosa. This particular vessel was derived from upstream of necrotic bowel. You can see that there is thrombus formation at the upper pole. There is necrosis throughout the vessel wall and disruption of the internal and external elastic laminae. This panmural vascular necrosis, with or without an active inflammatory infiltrate, is classic for PAN. The next slide shows the result of similar processes in cardiac tissue.

Centrally you can see a small vessel that is necrotic throughout with an inflammatory infiltrate, with a small vascular branch that goes off to the left and also has intense inflammatory infiltration. The muscle fibers in the fascicle that are adjacent to this vessel are infarcted. There are coagulation necrosis and loss of central nuclei. So, these are necrotic fibers. You can see some of the same changes to a lesser extent in the fascicle farther from this vessel. You can also see the edema and inflammatory infiltrates throughout the spaces between the bundles. So, this is a small myocardial infarction associated with a necrotic vessel and loss of perfusion. This next slide is of a sural nerve biopsy which represents one of the options in making this diagnosis. That is not a high yield procedure in a patient in whom you don't have involvement of the sural nerve distribution as indicated by electromyography and nerve conduction studies, etc. However, if you do, then you can make the diagnosis through biopsy of the sural nerve. You can see a small vessel in the upper part of this figure and necrosis in the wall in the upper right and there is inflammatory infiltration. This next slide shows the one diagnostic technique that might have been pursued in this individual had he survived and that might have provided a diagnosis ante mortem that would have allowed him to be treated, because this is a treatable disorder. This is a superior

mesenteric angiogram. In this patient, because of the involvement as indicated by the CT, etc., one would have been likely to do a celiac angiogram. There are fusiform dilatations and stenoses throughout all of these vessels like a sausage-on-a-string configuration. This could have made the diagnosis. Untreated, this disease has a five year survival of about 15%. Treated with steroids alone, there is a five year survival rate of 50-60%, and with steroids and Cyclophosphamide there is reason to expect that we may get five year survivals of 90% in polyarteritis nodosa. The possibility of treating that diagnosis successfully far outweighs the morbidity attendant to doing a celiac angiogram.

The terminal events in this patient support the diagnosis of polyarteritis nodosa. He had abdominal pain and pain irradiating to his left hamstring and knee followed by numbness in his left lower extremity. The typical picture of an evolving neural infarct, mononeuritis multiplex, is first pain and then numbness in the distribution of the nerve. Anatomically, it is very hard to put together what specific nerve would have gotten his hamstrings, his knee, and also his lower abdomen. One would put the infarct somewhere in the lumbar plexus, conceivably proximal to the sciatic nerve, but it is very hard to put this together anatomically. Nevertheless, this does look like the picture of a mononeuritis multiplex. He also had tachypnea, tachycardia, an S3 gallop, rales, hypoxemia, and interstitial infiltrates that responded to Lasix, Morphine, and oxygen. That is to say he had congestive heart failure with pulmonary edema. The finding of the S3 gallop suggests that may have been primarily of cardiac origin rather than say an ARDS picture where he had pulmonary edema based on a ruptured visceral organ. So, I think this person was having ischemic cardiac disease in the last day of his life. I think his edema on his earlier hospitalization suggested that he may have had an earlier infarct. Regarding what to expect on autopsy, I think the diagnosis of polyarteritis nodosa will be made. I think that there will be vascular lesions probably in multiple areas of the celiac axis. One may expect some old fibrotic areas in the heart as well as a fresh infarct occurring on the day of death. There may or may not be a finding of neural infarction because of the possibility of sampling error and you have a long neural structure that may need to be biopsied. Finally, the little defects in the liver are interesting and I would like to propose that those do represent small bile cysts. There is a disease called Caroli disease that is seen in neonates in which they have small cysts of the bile canaliculi and these can become infected and neonates can die from it. In the journal Radiology in 1979, there was one report of similar bile cysts in a patient with polyarteritis nodosa, which was by Doppman, et. al. They were able to reproduce that picture by infusing into the hepatic artery small emboli, thereby embolizing the liver of monkeys, to produce vascular lesions similar to polyarteritis nodosa and adjacent lesions of the bile canaliculi. So, it would not surprise me if you found epithelial-lined bile duct cysts in the liver of this patient. This disease is subject to sampling error in all organs and obviously a pathologist can not sample every millimeter of the tissue in the body. So, some of the things I have suggested may not have been detected at autopsy.

Dr. Willis: The autopsy was done on March 13th, approximately 10 hours post mortem. The gross findings were suggestive of congestive heart failure and included pitting edema of the extremities, pulmonary congestion and edema and a 500 ml pleural effusion bilaterally. The 400 gram heart was slightly enlarged and visceral congestion was noted throughout. Also seen were emphysematous changes in the lungs, an enlarged calcified hilar lymph node (which microscopically showed yeasts consistent with Histoplasma capsulatum, hyperemic and ulcerated areas scattered all along his GI tract, and atherosclerotic narrowing of his coronary arteries (up to 40% in some area).

Next, I would like to address some of the issues brought up in Dr. Wilson's discussion. The patient did have several enlarged abdominal and thoracic lymph nodes, but they were unremarkable histologically. No retroperitoneal mass was present and no grossly visible arterial nodules were found. We serially sectioned the liver and after careful examination did not find any lesions to correlate to the previously mentioned CT scan findings.

After completing the gross part of the autopsy, we still had not proven the cause of death. However, microscopic sections revealed severe necrotizing vasculitis in virtually every organ, with the notable exception of the lungs. The patient had vasculitis in all stages of development in almost every microscopic section examined. In one of the early lesions, you can see the inflammation around and within the vessel wall (Figure 1). The bright eosinophilic smudged appearance typical of fibrinoid necrosis almost completely replaced the vessel wall. In a slightly later stage, the fibrinoid necrosis and the inflammation remains and you begin to see fibroblast proliferation. In this example, the media is more intact and the fibrinoid necrosis does not completely replace the vessel wall. In an elastic stain at this stage of the disease, there is absence of the internal elastic lamina due to destruction of the media. Again, note the fibrinoid necrosis and inflammation which are prominent features.

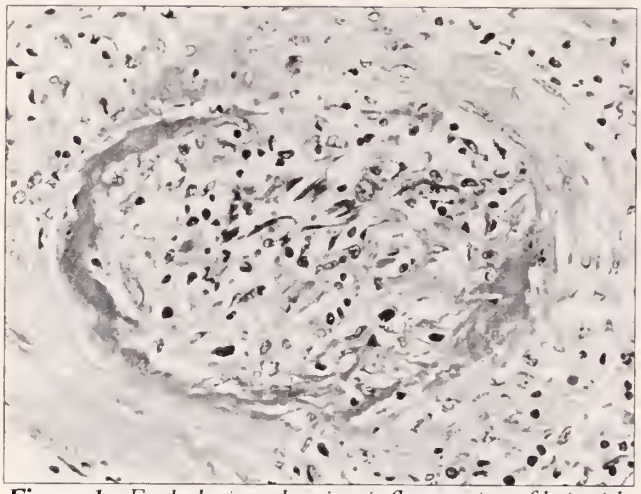


Figure 1: *Early lesion showing inflammation, fibrinoid necrosis*

The next example is a longitudinal section of a coronary artery with inflammation surrounding the vessel. A large amount of intimal proliferation nearly occludes the coronary. Damage to the media of this vessel is present with subsequent microaneurysm formation and the beginnings of a second microaneurysm (Figure 2). In a cross section of an elastic stained vessel, the same process of intimal proliferation with lumenal narrowing is noted. Destruction of the media and internal elastic lamina with microaneurysm formation is again seen.

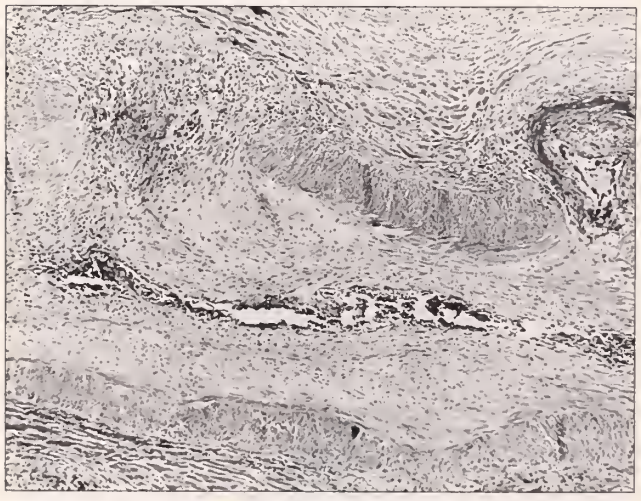


Figure 2: *Longitudinal section of a coronary artery showing inflammation surrounding the vessel, intimal proliferation which nearly occludes the coronary, and microaneurysm formation secondary to damage to the media.*

The healed stage is the final phase of this process. The inflammation is decreased, you can not longer see the fibrinoid necrosis, and fibroblast proliferation is more pronounced. In the healed stage of the disease process, you see scarring and a decrease in inflammatory cells. The first example of this stage from the patient is a vessel which had minimal disease. Most of the vessel wall is intact. Intimal proliferation with narrowing of the lumen is prominent and only in a small area do you see scarring of the vessel. On the other hand, this example shows the healed stage in a vessel which had severe vasculitis. A virtually acellular scar almost completely occludes the vessel and some intact media is present with a significantly decreased inflammatory process. An elastic stain of the healed stage again shows virtual occlusion of the vessel by an almost acellular scar and damage to the vessel wall circumferentially.

The patient had numerous pathologic processes associated with his vasculitis. Throughout the small and large intestine were ulcerated areas resulting from vascular occlusion. These most likely were the cause of his abdominal pain. A recent infarct was present on a section of kidney. The tests were atrophic and virtually no spermatozoa were seen in the seminiferous tubules. Autopsy material from the liver was unremarkable with no evidence of hepatocellular necrosis. Mild portal inflammation was noted, but these changes are seen in many autopsy livers. A section of kidney revealed no glomerular involvement, and lung sections contained no vascular lesions. However, there was a severe pulmonary interstitial fibrosis. On examination, birefringent material that appeared to be silica was seen, but the pattern did not appear to be silicosis. Apparently he had exposure to silica containing dust int he past which resulted in this fibrosis.

In conclusion, the characteristics and distribution of the vascular lesions led Dr. Kay Allen and myself to agree with Dr. Wilson's diagnosis of polyarteritis nodosa. The immediate cause of death was cardiac complications resulting from this disease.

Diagnosis: Polyarteritis Nodosa.

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DEESE, LAWRENCE E., Gulfport. Born Florida, October 14, 1957; MD University of South Alabama College of Medicine, Mobile, AL 1984; general surgery internship, Orlando Regional Medical Center, Orlando, FL, one year; cardiothoracic surgery residency, University of Missouri Medical Center, Columbia, MO, 1985-92; elected by Coast Counties Medical Society.

DHILLON, ROBIN K, Jackson. Born Singapore, September 11, 1958; MD Hahnemann University School of Medicine, Pittsburgh, PA, 1986; general surgery residency,, University Hospitals of Cleveland, OH, 1986-88; general surgery residency, University Medical Center, Jackson, MS, 1988-91; thoracic surgery residency, University Medical Center, Jackson, MS, 1991-93, elected by Central Medical Society.

ELLIS, T. B., III, Jackson. Born Jackson, MS, December 15, 1943; MD Meharry Medical College of Medicine, Nashville, TN, 1970; internal medicine residency, Meharry Medical College Medical Center, Nashville, TN, 1971-74; cardiology fellowship, University Medical Center, Jackson, MS, 1975-77; elected by Central Medical Society.

GOLDEN, JOE A., JR., Jackson. Born Witchita Falls, TX, July 21, 1965; MD University of Texas Medical Branch, Galveston, TX, 1991; anesthesiology residency, Same, 1991-95; elected by Central Medical Society.

GUEDON, DUNCAN F., Natchez. Born Natchez, MS, May 5, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1991; ob-gyn residency, University os South Florida Medical Center, Tampa, FL, 1991-95; elected by Homochitto Valley Medical Society.

HALE, GREGORY J., Tupelo. Born November 25, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1990p; internal medicine residency University of Alabama Medical Center, Birmingham, AL, 1990-93; nephrology fellowhship, same, 1993-95; elected by Northeast MS Medical Society.

HOLTZMAN, MOLLIE, Biloxi. Born Chicago, IL, Apri 3, 1964; MD Northwestern Universtiy Medical School, Chicago, IL, 1991; interned one year, University of Texas Medical Center, San Antonio, TX; physical medicine & rehabilitation residency, Baylor College of Medicine Medical Center, Houston, TX, 1992-95; elected by Coast Counties Medical Society.

IVEY, RICHARD K., Laurel. Born Natchez, MS, January 7, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1989; general surgery residency, Medical College of Georgia Medical Center, Augusta, GA, 1989-95; elected by South MS Medical Society.

KREGOR, PHILIP J., Jackson. Born Louisville, KY, December 26, 1962; MD Vanderbilt University School of Medicine, Nashville, TN, 1988; orthopaedic surgery residency, University of Washington/Harborview Medical Center, 1989-93; research fellow, A. O. Research Institute, Davos, Switzerland, 1993-94; orthopaedic trauma/pelvic & acetabular fellowship, Shadyside Hospital, Pittsburg, PA, 1994-95; elected by Central Medical Society.

LEE, JAMES DENNIS, Jackson. Born Tuscaloosa, AL, December 31, 1957; MD University of South Alabama College of Medicine, Mobile, AL, 1989; interned one year, University Nebraska Medical Center, Omaha, NE; anatomic/clinical pathology residency, Medical University of South Carolina Medical Center, 1991-94; dermatopathology fellowship, same, 1994-95; elected by Central Medical Society.

LOTT, JIMMY WALTER, Jackson. Born Houston, MS, Novebmer 16, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1986; medi-

Medical Center, Memphis, TN, 1986-87; internal medicine residency, same, 1987-89; cardiology fellowship, same, 1989-92; cardiac electro physiology fellowship, Case Western University Medical Center, Cleveland, OH, 1987-89; elected by Central Medical Society.

McCRIMMON, MELYNDA C., Greenwood. Born Kosciusko, MS, December 2, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1992; pediatric residency, same, 1992-95; elected by Delta Medical Society.

MULLHOLLAND, DAVID H., Jackson. Born Greenville, MS, July 29, 1953; MD University of Mississippi School of Medicine, Jackson, MS, 1981; internal medicine residency University Medical Center, Jackson, MS, 1980-83; cardiology fellowship, same, 1986-89; elected by Central Medical Society.

REED, J MARK, Jackson. Born Jackson, MS, June 23, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1989; pediatric residency, University Medical Center, Jackson, MS, 1990-94; pediatric otolaryngology residency, Children's Hospital Medical Center, Cincinnati, OH 1994-95; elected by Central Medical Society.

ROBERTSON, JON H., Greenwood. Born Memphis, TN, Junes 25, 1946; MD University of Tennessee College of Medicine, Memphis, TN, 1971; general surgery residency, City of Memphis, Hospitals, Memphis, TN, 1973-74; neurosurgery residency, University of Tennessee Medical Center, Memphis, TN, 1975-79; elected by Delta Medical Society.

SHATLEY, MIRIAM J., Jackson. Born Zeeland, MI, November 22, 1961; MD University of Arkansas School of Medicine, Little Rock, AR, 1988; pediatric residency, University of Missouri Medical Center, Columbia, MO, 1988-91; dermatology residency, same, 1991-94; elected by Central Medical Society.

SHERMAN, ROSS KELVIN, Waynesboro. Born Ft. Carson, CO, November 18, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; family practice residency, Tuscaloose Family Practice Program, Tuscaloosa, AL, 199-93; obstetrics fellowship, same, 1993-94; elected by South MS Medical Society.

SISAM, RANDALL L, McComb. Born Des Moines, IA, September 16, 1963; DO University of Osteopathic Medicine & Health Sciences, Des Moines, IA, 1990; one year internship Mount Clemens General Hospital, Mt Clemens, MI; obg residency, Memorial Hospital, Stratford, NJ, 1991-95; elected by South Central Medical Society.

SMITH, NORWOOD MARYE, Jackson. Born Columbus, MS, March 25, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1987; internal medicine residency, Georgetown University Hospital, Washington, DC, 1987-90; radiology residency, University Medical Center, Jackson, MS, 1990-94; elected by Central Medical Society.

STEVENS, CLAUDINE S., Greenwood. Born Charleston, MS, December 25, 1965; MD University of Mississippi School of Medicine, Jackson, 1991; pediatric residency, University Medical Center, Jackson, MS, 1991-94; elected by Delta Medical Society.

TAYLOR, MALCOLM P., Jackson. Born Vicksburg, MS, November 16, 1947; MD Tufts University School of Medicine, Boston, MA, 1973; internal medicine residency, Washington Hospital Center, Washington, DC 1974-76; cardiology fellowship, Georgetown University Hospital, Washington, DC, 1976-78; elected by Central Medical Society.

THAMES, CYNTHIA L., Laurel. Born Evansville, IN, August 11, 1959; MD American University of the Caribbean, British West Indies, 1989; interned one year, Sacred Heart Medical Center, Spokane, WA; anesthesiology residency, University of Texas Medical Center, Galveston, TX 1990-93; elected by South MS Medical Society.

WEISENBERGER, SARA J., Jackson. Born Yazoo City, MS, May 4, 1955; MD University of Mississippi School of Medicine, Jackson, MS, 1991; pediatric residency, University Medical Center, Jackson, MS, 1991-94; elected by Central Medical Society.

WHALLEY, KEVIN MICHAEL, Grenada. Born Bossier City, LA, May 7, 1963; MD University of Tennessee College of Medicine, Memphis, TN, 1990; orthopaedic surgery residency, LSU Medical Center, Shreveport, LA, 1991-95; elected by North Central Medical Society.

WHITAKER, SCOTT D., Oxford. Born Columbus, MS, July 16, 1962; MD University of Alabama School of Medicine, Birmingham, AL, 1993; oral & maxillofacial surgery residency, Same, 1989-95; elected by North MS Medical Society.

REINSTATED:

MICHAEL T BOLER, Greenwood
JACKSON E FOWLER, JR, Jackson
JAMES C. FUNDERBERG, Ocean Springs
J. W. LEWIS, JR, Rosedale
BRYAN F. MCCRAW, Columbia
DAVID G. WATSON, Jackson

DEATHS:

LUNCEFORD, WM. H., Sardis. Born Slate Spring, MS, June 26, 1913; MD University of Tennessee Collgcg of Medicine, Memphis, TN, 1941; interned one year, Methodist Hospital, Memphis, TN; died September 24, 1995, agc 82.

Personals

Robert Rhodes, MD, surgery department chair at the University of Mississippi Medical School has changed jobs to become the medical director of University Hospitals and Clinics. Dr. Richard Miller, professor of surgery (pediatrics) will fill in as interim surgery department chair until a search for a chair can be completed. Vice chancellor Dr. A. Wallace Conerly and hospital director Ted Woodrell said Dr. Rhodes' experience and interest in health care financing make him an ideal choice for his new post.

Ben Douglas, MD's latest book for children by UMC, *What Is There to Do in the Country?,* tells the story of a city cousin who spends a week with his country cousins in Sontag, reluctantly at first, then with growing enthusiasm for life in the country. The book retails for $13.95, but Dr. Douglas assistant vice chancellor for graduate studies, will sell 100 copies of the book for $12, $6 of which he will give to the UMC Children's Hospital. The book is illustrated with 26 original watercolor paintings by Mary Lane Reed, a local artists whose works hang in many corporate collections in the state. All books are signed by both author and illustrator, and Dr. Douglas has agreed to personalize copies if the buyer wishes. The books will be available in the UMC public affairs office as long as they last.

Martin Steinberg, MD, professor of medicine, has received high praise from reviewers. Dr. Louise Tillyer of the Royal London Hospital says in Lancet, "I can thoroughly recommend this excellent book to anyone involved in the care of patients with this fascinating but often terrible disease." Dr. Paulette Mehta of the University of Florida in the *New England Journal of Medicine* says she recommends the book "for its content, its authors, and their perspective and optimism" and says it is "must" reading for hematologists." Dr. Rodger L. Bick of the University of Texas, Southwestern, in the Journal of Clinical Applied Thrombosis and Hemostasis calls it "an extraordinarily fine textbook" and a "welcome addition to the armamentarium." The other editors are Dr. Stephen H. Embury, Dr. Robert P. Hebbel and Dr. Narla Mohandas. It was published by Raven Press of New York.

Ralph Vance, MD, professor of medicine, has been appointed to a second term on the American Cancer Society executive com mittee, marking the first time a Mississippian has been elected twice. "I'm honored to be chosen again and honored to be able to represent Mississippi," he said. Committee membership consists of 30 people from throughout the nation. The committee makes recommendations to the ACS board of directors, composed of 200 members.

Joey Granger,MD, professor of physiology and toxicology, served as guest editor for the proceedings of the Inter-American Society of Hypertension in Montreal, Canada, this summer. The society will publish selected peer reviewed manuscripts from the proceedings in the Hypertension Journal in December, 1995. Dr. Granger was also appointed to a three-year term on the editorial board of the American Journal of Physiology, the official journal of the American Physiological Society.

Lessa Phillips, MD, family medicine department chair is one of four associate editors of a new textbook, *Fundamentals of Family Medicine,* edited by Robert B. Taylor, published by Springer. The book was compiled as a course text for family medicine clerkships to present common problems in generalist practice.

George Abner Lauderdale, MD, was honored for his two generations of service during an unveiling and dedication ceremony of his portrait to hang in the pediatric unit of Rush Foundation Hospital in Meridian, MS.

Jaime Jimenez, MD, opthamology surgeon, was awarded the Preserve Sight Mississippi "People of Vision Award at a charity dinner. He was roasted by Drs.Thad Waites, and D.B. Conerly.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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Detection Of Diabetic Nephropathy And Use Of Ace Inhibitors In Its Trea

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Background:

•A 1993 study established a new standard of treatment for patients with diabetic nephro found that the use of angiotensin-converting enzyme (ACE) inhibitors significantly slowec of the disease and reduced dialysis, kidney transplants and death by 50%.

•Diabetes accounted for 17.65% of Mississippi's Medicare hospital discharges from Jai June 30,1994.

Purpose:

•Establish baseline data on use of ACE inhibitors in treatment of diabetics.

•Establish baseline data on early detection of diabetic nephropathy.

•Improve the detection of nephropathy and use of ACE inhibitor treatment.

Methodology:

•The Foundation's abstraction tool collected diabetic admissions, diagnostic testing of renal function, and ACE inhibitor use.

•Statewide stratified random sample of charts reviewed (893 charts of patients with primary/ secondary diagnosis of diabetes between January 1, 1993, and June 30, 1994).

Findings:

•About 69% of the diabetic patients reviewed had urinalysis protein screening performed.

•About 40% of the patients screened had urinary evidence of nephropathy.

•About 96% of patients with negative dipstick protein did not have a more sensitive microalbumin evaluation.

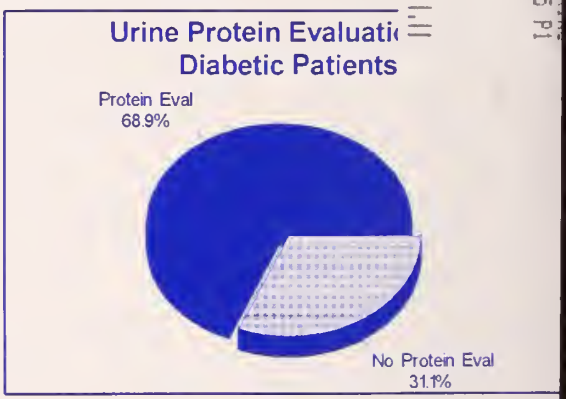
•About 26% of diabetic patients with evidence of proteinuria without infection received ACE inhibitors at discharge.

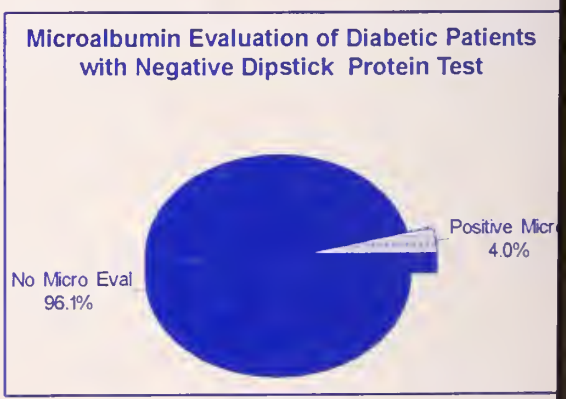
Conclusions:

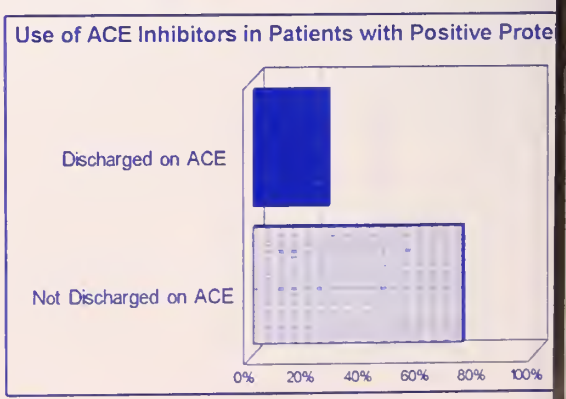
•Opportunities for improvement were demonstrated.

•Foundation shared findings with providers in June 1995.

•Educational video in production to be offered initially to collaborating providers.







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